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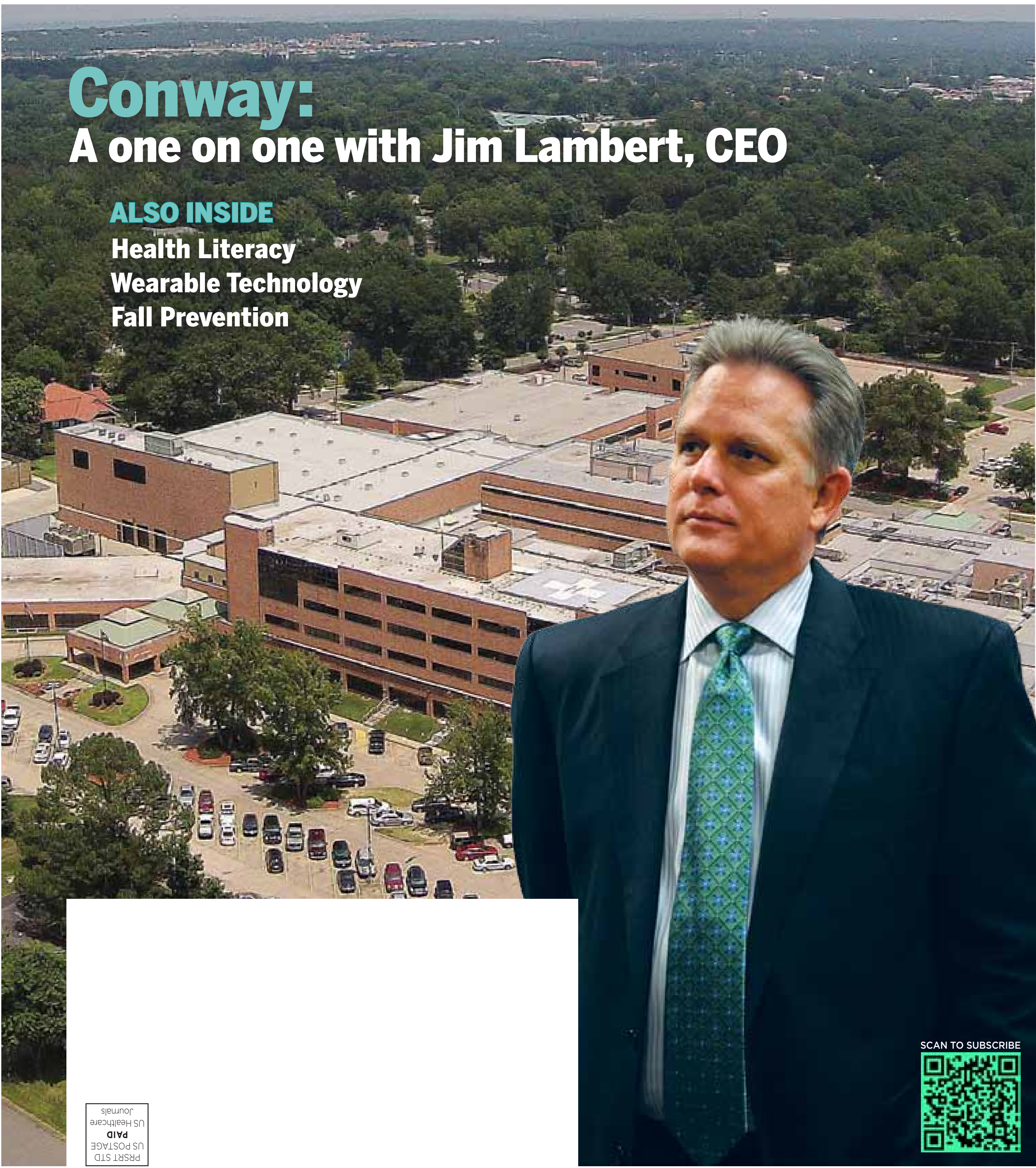
SEPTEMBER / OCTOBER 2014 | HEALTHCAREJOURNALLR.COM | $8



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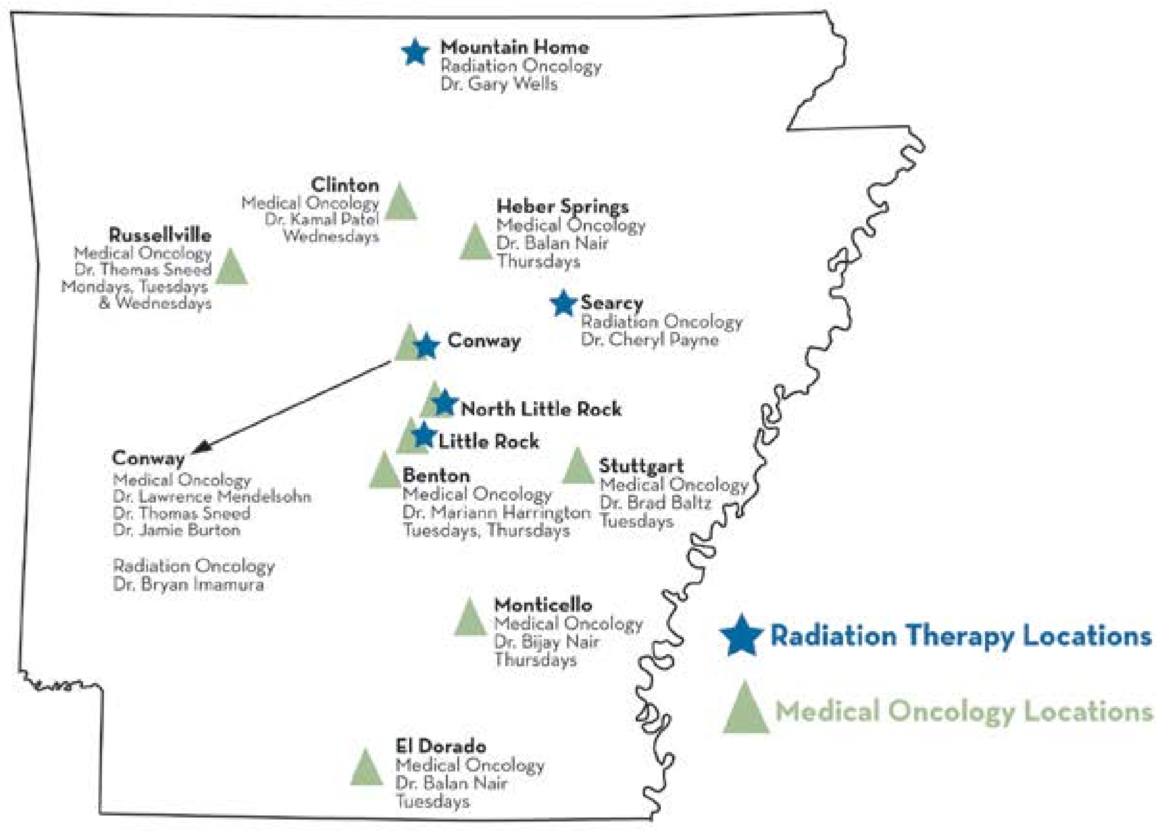

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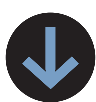

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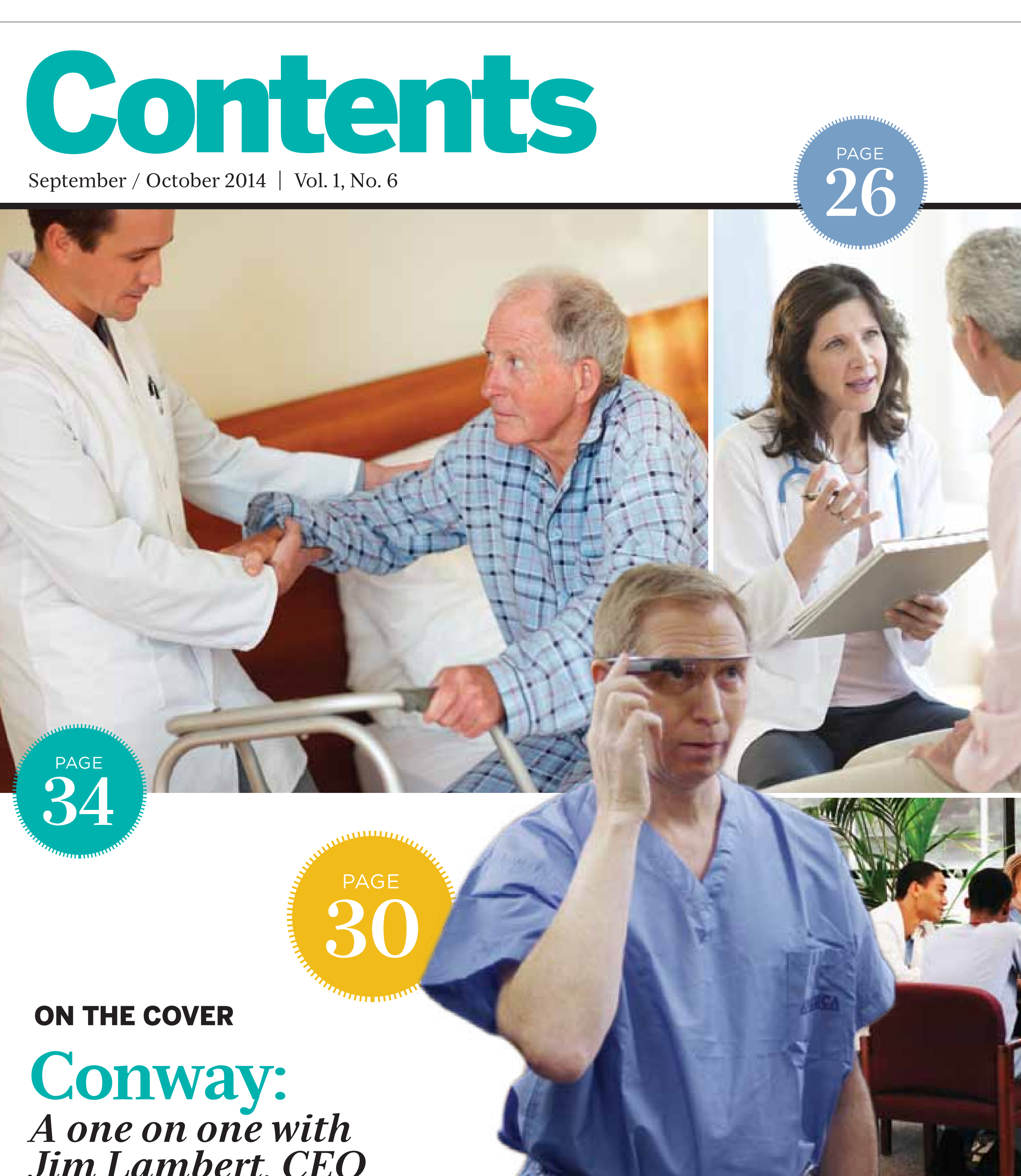
Contents

September / October 2014 | Vol. 1, No. 6



PAGE 26

PAGE 34

PAGE 30

ON THE COVER

Conway:
A one on one with Jim Lambert, CEO
PAGE 12

PAGE 12

PAGE 20

Features

20 **The Rating Game**
Increased transparency helps drive quality initiatives

26 **Say What?**
UAMS Center tackles health literacy

30 **Healthcare You Can Wear**
Are you ready?

34 **Fall Focus**
Joint commission, local hospitals take closer look at fall prevention

Departments

Editor's Desk 10
Healthcare Briefs 39
Hospital Rounds 57
Advertiser Index 66

Correspondents

Director's Desk 46
Policy 48
Quality 52
Nursing 54

If anything unfolds, it's supposed to.

— JOHN FRUSCIANTE

We shouldn't underestimate the importance of epidemiology as it relates to health. We all have a history to our present state of health, which includes genetics, environmental issues, and behavioral decisions. But, I'm not talking about quantitative epidemiology. I'm referring more towards an intuitive epidemiology.

Most of our diseases are linked to a lifetime of psychosomatic effects on the body from our own thoughts. As children we were subject to an educational system designed to deliver facts such as the existence of nine planets, the smallest of which was Pluto. But few of us as children learn to properly manage our own minds in a way that doesn't make us subjects to them. Our ability to manage our thoughts will have a profound effect on our personal health decisions both consciously and unconsciously.

We have developed a wonderful society of comfort and functionality. So why is stress one of the most harmful diseases in our culture? It's not because our society needs more perfecting. It's because most people haven't learned daily human living skills. It's understandable. Remember the 1962 musical *The Music Man*? In the production, Professor Harold Hill comes to a small town in Iowa to make money as a salesman. However, before he can sell anything, he knows he needs to create a problem. So he creates stress and unrest so that he and his product can save the day.

This is the constant message we receive in our society. The world has learned that your stress is a benefit to its advancement. So be equipped. The message is simple. You are not happy until you buy (fill-in-blank), or elect (fill-in-blank), or achieve (fill-in-blank).

It's a false promise of future happiness. But, it doesn't work. It doesn't work because you are developing a pattern of discontentment. Discontentment then manifests into anger, worry, and stress. By the time you get where you were going, you will simply become discontented with something else. This is the pattern.

I don't think the marketing efforts of companies, media, and politicians intend to put us in a perpetual lifetime state of discontentment. I think they want us to be discontented just to the point of buying what they are selling. But, the impulses on us are perpetual. And, by evidence of modern stress, most have not yet learned to properly handle these messages.

In *The Music Man*, the people of Iowa bought Hill's band equipment and then returned to normal. In our world, the next sales pitches are right around the corner.

If you are grateful today, you have a better probability of being grateful tomorrow.

If you are content today, you have a better probability of being content tomorrow.

This is a pattern. Patterns of the mind are real.

This is intuitive epidemiology–things we just know.

Every thought comes from an impulse. Humbly know yourself.

Smith Hartley
Chief Editor
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#1 CHI St. Vincent Infirmary
#2 University of Arkansas for Medical Sciences

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- *Arkansas Surgical Hospital*
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For one of the nation's most trusted sources to rank us so highly – ***for the second straight year*** – is confirmation that our hard work is improving the lives of Arkansans. *U.S. News & World Report* rankings are the gold standard for everything from picking the best car to choosing a top university. Why not when you're making decisions about health care? Your family's health is too important to settle for anything less than the best.

Imagine better health.[SM]

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Conway

A One on One with Jim Lambert, CEO

Jim Lambert has served as the President and Chief Executive Officer of Conway Regional Health System since April, 2008. He previously served as Conway Regional's Chief Operating Officer for 10 years.

Lambert came to Conway after serving in vice president positions at Covenant Health in Knoxville, Tennessee and at Community General Hospital of Thomasville, North Carolina.

He received his Bachelor of Arts in Biology from the University of California in San Diego and his Master's of Health Services Administration from George Washington University in Washington, D.C. He is board certified in healthcare management as a Fellow in the American College of Healthcare Executives and is a 2010 graduate of the Leadership Arkansas Class IV.

In addition to being President and CEO at Conway Regional, Lambert was appointed by Governor Beebe in 2009 to serve on the Arkansas State Board of Health and he has served as director on the Arkansas Hospital Association Board, the VHA Oklahoma/Arkansas Board, and is a member of the Rotary Club.

HOSPTIAL IMAGE COURTESY OF CONWAY

Chief Editor Smith W. Hartley **Can you characterize the population in the area you serve?**

Jim Lambert I think it's a highly educated community, especially in Faulkner County. You've got the three colleges in the community, which drives a lot of that and attracts that kind of population. We've got HP with its new office here in town, and Axiom, which are more high tech kind of industries. There is a mix of manufacturing, high tech, information management, so it makes a nice blend. I think that helped us during 2008 when everything went down. Conway kind of stayed a little bit flat. We dropped a little bit, but not nearly to the extent maybe that northwest Arkansas did in terms of values and impact on the business. And I think that's because of our diversity of businesses that we have in the community.

Editor Do you consider yourself a rural or an urban hospital?

Lambert I think we consider ourselves a mix of the two because Conway is a fairly urban community, but once you get outside of Conway, Faulkner County, Cleburne County, Conway County, Perry County, those are all very rural. So we are dealing with the issues that rural counties have, which is access out in those communities, as well as then dealing with the urban issues here. From a Medicare standpoint, CMS considers us urban; we are part of the Little Rock MSA. There are some advantages and disadvantages to that. There are programs for rural hospitals that we can't take part in, but there are some things that are advantageous to being part of the Little Rock MSA as well.

The average age in Conway is about 23 or 24, but once you get outside, the average age goes up. I think in Faulkner County the average is about 37. Which is why we still have a fairly high Medicare percentage. It makes it a challenge to manage the diversity of the populations we serve.

Editor Can you talk a little bit about the in- and out-migration? Do people stay in Conway for healthcare?

Lambert It depends a little bit on what you are looking for. For example, for OB we capture about 80 percent. For other services it depends, but there is a fair amount of out-migration to Little Rock. We are only 27 miles down the road to four or five major institutions that we compete with on a daily basis. So we do see people leave and a lot of times it's for things that we'll never do–transplants, high-end pediatric care–Children's is right down the road and we do some pediatric care, but not to the extent that Children's does. They do it so well there is no sense in trying to replicate that this close. So there are things like that that people leave for–some different types of surgery–we don't perform any neurosurgery, but we do perform 120-150 open hearts a year and have a full-service cardiology program. We also have a pretty broad spectrum of specialty coverage.

Editor With regards to your population, can you talk a little bit about the payer mix?

Lambert It's a pretty decent payer mix. It's probably 50% to 54% Medicare, Medicaid is about 8%, managed care about 30%, and we are seeing about 5% self-pay.

Editor What are some of the things you are proud of here?

Lambert We are really proud of our women's services. And our open heart program is rated number one in the state by CareChex and Healthgrades, based on outcomes. We are not the biggest heart program in the state, but based on our outcomes we were rated number one by those two services. We have a 26-bed acute rehabilitation hospital that we have done in a joint venture with our physicians and that's a very strong asset to the community. That was one service for which people were leaving and we were able to bring it into the community in a high quality way. Our mindset is that if we are going to do something like open heart surgery or inpatient rehab, we are going to do it as well as Little Rock, Memphis, Dallas, M.D. Anderson, whatever, because that's who we compete with. People are out-migrating out of Little Rock to get healthcare, too. So we want to make sure our patients know that if they come here they are getting just as good care as anywhere else. At least that's our goal.

Editor What's the value in being an independent hospital?

Lambert I think there are a lot of good things about that. We're community-focused. It allows us to do what we want to do without someone else telling us, "We think you should really be doing x, y, or z." That self-determination to some extent and truly being able to focus on the needs of this community, not worrying about how this community fits within a broader spectrum or context. But I have worked in large health systems and there are positives to that as well.

Editor Baptist is coming to this area. What does that mean for Conway?

> **We also want to work to develop partnerships with our docs and with employers to figure out how to keep these people well, which ultimately is what our goal should be, as well as, if they get sick, how do we move them through the processes as quickly as we can to get them back to work, back home, doing what they want to do...**

Lambert Our understanding is Baptist is building a hospital here—they've had a groundbreaking for a $130 million hospital in Conway. Obviously we are looking at the impact on the community and on us. That's one of the reasons, along with the Accountable Care Act and the other things we are seeing with the future of healthcare, that drove us to look at our relationships with other health systems and seeing what we can do to be successful going forward. Our board has been very proactive in the past to get us to where we are and I think we are being proactive now in looking at where we need to be, to be a strong, viable organization to meet the healthcare needs of this community.

One of the things we are doing is we are looking at a relationship with CHI St. Vincent; not a sale, not a merger, but a partnership—to see what we can do together to drive value. For both of us that means value to our patients, in both communities that we serve.

When you asked about services that we are proud of, I think what we are most proud of is our ability to meet the needs of this community over the last 75 years and to maintain that. Conway has gone from 5,000-10,000 people to 60,000 people, and we provide a broad spectrum of specialties across the healthcare continuum. Our ability to do that has really been led by the board and their vision and where we wanted to be, and the leadership before me to get us to this point. So, positioning ourselves to make sure we can meet the needs of this community has been, I think, one of our proudest things.

I THINK WHAT WE ARE MOST PROUD OF IS OUR ABILITY TO MEET THE NEEDS OF THIS COMMUNITY OVER THE LAST 75 YEARS AND TO MAINTAIN THAT.

If you look at infrastructure in Conway we are one of the parts that have really kept up... roads, maybe not so much. Obviously every growing community has their issues and we have ours as well.

So we are going to compete with them like we have competed with them for the last 75 years...they'll just be two miles down the road versus 27 miles. It's just a different level of competition I guess.

Editor Can you tell me a bit more about what the potential partnership with St. Vincent would entail?

Lambert I think what we are discussing is can we develop some sort of joint venture that we both own that we do things through—contract, buy supplies, outsource various things—so we can both drive value to each other, but still maintain our independence? Our board is pretty committed to maintaining as much independence as possible because we feel like healthcare is a local industry and needs to be driven by local decision makers and we want to do that as long as we can.

Editor How has the Affordable Care Act affected Conway Regional's strategic planning?

Lambert It has affected us both as an employer and as a provider. Because really the Accountable Care Act is health insurance reform, not healthcare reform. So we

are trying to deal with all the challenges that come with changing the way hospitals are paid, moving from fee-for-service, to where you are being paid for value, for providing high quality care, not volume. So we are making sure our quality is there, making sure our costs are where they need to be, while maintaining the quality, and positioning ourselves to take risks in the long run.

I think we are going to have to take risks, partnering with our physicians. To be accountable for the care of a block of patients or community members, saying, "We'll take care of them for 'x' dollars and that's all your liability is" and we'll take the risk. We are a long way from that in Conway and that's one of the reasons we are looking at a larger organization like St. Vincent. To take on that kind of risk you have to have some skill sets we don't necessarily have as a community hospital. So tapping into that skill set that St Vincent is able to have because of their size and scale and their presence in other markets will help position us to be successful going forward.

And as an employer, we are trying to keep our healthcare costs down like everyone else. We did wellness for our employees, incenting them to take care of themselves, because we are self-insured and every dollar we spend, the rates go higher. If we can save it then we can reduce the costs going forward for our employees, plus we have healthier employees.

Editor Is this partnership going to happen soon?

Lambert I am hoping that we have it defined in the fall and have a definitive agreement in place by then.

Editor Can you talk a little about Conway Regional and technology–where are you operationally?

Lambert We feel like we have a lot of really strong equipment and technology for the physicians. We built our brand new OR suite three years ago so we have larger ORs, more technologically integrated. Really we don't take a back seat to anybody in the state related to our surgical services, technology, and how that facility is operationalized.

The same thing in women's services; we have expanded our women's center over time and we have what we feel is a state of the art women's center for this region and we deliver over 1900 babies a year.

We feel like we are keeping up with that and we make sure our doctors have the equipment and technology that they are used to training with. We have the DaVinci surgical robotic system, CT scans, MRIs, all those things we feel we need to have, and it's all state of the art.

Editor What about in terms of health information technology?

My oncologist asked me, "Do you want to go to M.D. Anderson or Mayo?" and I said, "Well, can we do it here?" She said yes, so why would I want to go anyplace else, right? It's five minutes from home, I know what kind of care I am going to get, so everything worked out great, other than being in the hospital 27 days and losing my hair for a while.

Lambert Yes, we are going to a fully electronic medical record and so we are going through the trails of converting from paper to electronic and getting the doctors to go along that path with us. We are seeing a significant shift of resources going into IT and information systems, developing networks, portals for patients to access their charts, and looking at how we share data between hospitals and physicians and making sure that connectivity is there. I think the unfortunate thing in healthcare, unlike banking, is we don't have a universal language to transmit information to each other. In banking it's all the same, you just plug and play. In healthcare, you have to try to write interfaces to everybody's electronic record and it's a disaster to try to figure out how to do that. If we had been able to come up front and say, "Here are standards that everybody has to adhere to in how we are going to share information," before everybody built their systems we'd be a lot further along in sharing that data. We are working with the Arkansas SHARE (State Health Alliance for Records Exchange) Network and we've got our portal open; it will be a way to share information out to providers.

Editor What is coming next on the horizon?

Lambert We are trying to figure out how do we position ourselves to be successful in the future? How do we take on risk? How do we drive value to the patients and to the employers in the community and make sure they are getting value for their dollar? They spend a lot of money in healthcare. We need to make sure we're using those dollars wisely, efficiently, and effectively so they get value. We also want to work to develop partnerships with our docs and with employers to figure out how to keep these people well, which ultimately is what our goal should be, as well as, if they get sick, how do we move them through the processes as quickly as we can to get them back to work, back home, doing what they want to do and not languishing in the hospital taking up healthcare resources?

That's going to take some patient and personal accountability in that process. If the doctor orders you to do such and such and such, you'd be surprised how many people don't do that. Making sure people are taking their medications as they are supposed to, going to see their doctor as they are supposed to, staying on the diet they are supposed to—maintaining compliance with that is a huge part of maintaining wellness. We are going to have to figure out how we are going to do that. Some hospitals are partnering with universities to develop health coaches that then call patients and say, "Have you done this today, have you done that today?" making sure they are doing what they should be doing. We are probably going to have to look at things like that as well. So looking at ways to again, bring value and drive wellness as well as reduce cost on the healthcare side.

Editor I understand you had an opportunity to experience Conway Regional from a rather unique perspective.

Lambert Almost two years ago I was diagnosed with leukemia, acute promyelocytic leukemia, which is, fortunately for me, one of the most curable forms—it's like a 90-95 percent cure rate. Most of the issues occur in the first 30 days so I was in the hospital for about 27 days. My oncologist asked me, "Do you want to go to M.D. Anderson or Mayo?" and I said, "Well, can we do it here?" She said yes, so why would I want to go anyplace else, right? It's five minutes from home, I know what kind of care I am going to get, so everything worked out great, other than being in the hospital 27 days and losing my hair for a while.

> **THAT'S SORT OF OUR MOTTO, "YOU DON'T HAVE TO GO ANYWHERE ELSE TO GET GREAT CARE; YOU CAN GET IT RIGHT AT HOME."**

But it's gone ex-tremely well. I got great care. My oncologist, Dr. Tsuda, did a great job and it has been relatively easy. I didn't have a lot of the other side effects people going through chemotherapy have, like nausea and vomiting. I had about three or four rounds of chemo and I have been on maintenance drugs for the last two years.

Editor So what was your prognosis?

Lambert It's a blood disorder. My blood was developing a whole bunch of immature white cells and going out of control. My platelets were almost non-existent, so I had bruises everywhere, the blood wasn't clotting. You can have internal bleeding, which can kill you, so that's where the mortality occurs. I got maybe 25-30 units of blood, all kinds of blood products, and that was keeping the hemoglobin, hematocrit, white cells all in balance...it was a juggling act that my oncologist had to do for the first 27 days. It's sort of like a hard crash on your computer; I just had to go through a reboot, get the blood marrow producing the right kind of blood cells and restart the process. It seems to be working great.

There were times when my white count was so low I couldn't really be around people, because my body didn't have the ability to fight off infections. I couldn't go outside, couldn't eat fresh food or vegetables, it was kind of wild.

It's been two years and my white counts are good. I see my oncologist quarterly now and in December I will be off maintenance. I think after two years you are getting close to being labeled as "cured" so it's not like a cancer of an organ or anything like that, that can reoccur. Nothing like some people go through with their cancer treatment.

Editor But that must have given you a deeper perspective of the patient experience at your hospital. Did you learn anything that made you a better administrator?

Lambert I think so. I think you also understand what the nurses go through on a day to day basis, and the challenges they face and what the patient looks at on the four walls. One of the things we are looking at doing, part of it is competitive, but some of it is we just need to do it, is renovating our whole patient tower to make the rooms more aesthetically pleasing. When you are laying in the room and looking at the four walls, you are thinking, "This is not very comfortable. This is not very attractive." The food is good, but after about a week, you get tired of it.

We are also looking at flow and process. We just implemented our electronic record and we had an issue where somehow my chart got like 300,000 interventions on it and almost crashed the system. So looking though and making sure the process works for the nurses on the electronic system, too.

You've seen some of the movies like Patch Adams, where they talk about experiencing it from the other side. It's probably not a bad idea for doctors and healthcare workers to be at least a mock patient to understand what we do to patients. I try to tell the employees, when a patient comes in, what's the first thing we do? We take their clothes away, we give them a gown that flaps in the back, and then we stick them everywhere, and we wonder why they are not happy. They don't want to be here. How do we overcome that and make this a better experience for them? My team did a great job. The nurses were phenomenal and I don't think it was just because I'm the CEO. At first I think it stressed them out, but after a week, I was just a guy. I think it is hard on the family more so than the patient.

Editor Was that room your administrative office while you were sick?

Lambert A little bit, although I had my assistant, who has since retired, and she was sort of the guardian of the door. Everybody had to go through her to get to me and she would make sure my time was limited. But I would check email. I tried to stay connected. We had the opening of the new surgery tower right when I was in the hospital so I couldn't go to that. We also had a big golf tournament and a community health summit, all during that time and I couldn't attend. My team did a great job though—they barely missed me. It turned out great so I can't complain. I got great care and didn't have to go anywhere. That's sort of our motto, "You don't have to go anywhere else to get great care; you can get it right at home."

Editor So now what is your personal intention at Conway? Do you plan to stay on in this capacity?

Lambert I have no desire to go anywhere else. If something comes up you never know, the board may decide I need to move on. The lifespan of a healthcare CEO is around four to five years and I've been here seven as the CEO, so I guess I am dancing on borrowed time already, but I'd like to stay. The great thing about being at Conway Regional and in Conway is I have been able to grow and develop with my team along with the hospital, gaining new experiences, and new professional growth without having to go someplace. Early in my career I moved around—I was in Oregon, North Carolina, Tennessee, and since then I have been here. Sometimes you have to move around to get experience and sometimes you can stay put. ■

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the rating game

Increased transparency helps drive quality initiatives

By **John Mitchell**

In a recent study [1] led by a Georgetown University researcher a correlation was found between surgical mortality rate and whether or not a surgeon had operated the day before. In reporting on the study NPR science correspondent Shankar Vedantam concluded by noting: “I think every explanation starts however, with trusting the data and not trusting our intuitions about these outcomes.”

A decade ago such a study would have likely elicited protest—or at least dismissal—at the average hospital. The degree to which hospital administrators and medical staffs looked outside their own walls to evaluate quality, safety outcomes, and patient satisfaction varied widely with no common standard. After all, independent medical judgment has long been a hallmark of physician training in the U.S. For hospitals, if a facility wanted to proclaim itself "A Center of Excellence", it could do so with an ad in the newspaper touting its compassion and technology, rather than outcomes and safety.

Since 2005 much has changed. Transparency focused on quality and outcomes data has transformed the way doctors and hospital managers now go about their business. Hospitals began widespread tracking of medical errors in 2000 and the Centers for Medicare and Medicaid Services (CMS) began collecting hospital quality data in 2003. However, with the launch of its Hospital Compare website[2] in 2005, CMS made transparency part of the cure to decrease preventable medical deaths and improve patient satisfaction. The data at this site posts information on over 4,000 Medicare-certified hospitals across the country out of a total of 5,000 registered community hospitals in the U.S.[3]

On the site, consumers (patients) can choose a zip code, city, state or specific hospital. The site allow up to three hospitals at a time to be compared. There are 10 questions pertaining to patient satisfaction ("Patients who reported that they 'always' received help as soon as they wanted"); 10 categories under "Timely & effective care" for such conditions as heart attack and blood clot prevention; readmissions, complications, and deaths; and use of medical imaging.

For Roxane Townsend, MD, CEO at UAMS Medical Center since February of 2013, measuring quality of care and acting on the data is a priority. Townsend came to UAMS from LSU Health which she reports has "a very robust" quality program. She offers the 3,000+ people who work at UAMS the unique perspective of serving as both a registered nurse for nine years and as a medical doctor, graduating in 1992 after completing an internal medicine residency.

"When I got here it seemed to me there was a lot of what I call admiring the problem," she said. "There was focus on the data, but what we needed was to be pro-active in developing action plans to improve. In the past 15 months it's been really remarkable to see the increased engagement from the medical staff on quality."

She signaled her focus on this goal when she appointed Chris Cargile, MD, Chief Medical Quality Officer.

"We needed to elevate the quality function so that the office was on equal stature with the Chief Medical Officer," she explained. Dr. Townsend said the Chief Medical Officer has the clout to hold people accountable and a sense of urgency in improving the Hospital

“Our newly focused patient-centered culture allows us to get consensus by realizing that business as usual is not going to help us get better.”

–Roxane Townsend, MD, CEO, UAMS Medical Center

Compare and other quality measures. She and Dr. Cargile cited UAMS work on central line infections as an example.

“Our scores weren’t bad,” said Dr. Townsend. “But I found an early champion in the ICU who wanted our care to be extraordinary – not just for Little Rock, but in the entire country.” She said the ICU was soon at zero infections using the score as an improvement tool. The staff created a “persuasive” culture

Roxane Townsend, MD

Chris Cargile, MD

of quality care by changing the protocol for putting in central lines.

“In the old days, It was a matter of washing your hands and putting on gloves,” she explained. But using such quality processes as LEAN and/or Six Sigma, the staff added protocols such as gowning and draping. “Those steps take more time, but the staff understands it’s worth it when we can get the infections down to zero,” said Dr. Townsend. She noted that while doctors can have many different opinions, in the end there was no push back in following the new hospital guidelines.

“Our newly focused patient-centered culture allows us to get consensus by realizing

SURGEONS EXPECT TO CONTINUOUSLY IMPROVE SO THE DATA IS VERY POWERFUL

that business as usual is not going to help us get better."

At Baptist Medical Center, Chief Medical Officer Eddie Phillips, MD, a longtime OB/GYN on the medical staff, said the big hurdle with the medical staff that has been cleared is the credibility of the CMS Hospital Compare database.

"When quality data first came out there was an attitude among doctors that this is really not my problem. There wasn't a belief in transparency, but that has changed," said Dr. Phillips. "Now we get engagement from everyone, not just the great performers. Outcomes are the norm and we trust the data now." Dr. Phillips noted that surgical measures, such as the Surgical Care Improvement Project (SCIP), which is a national quality partnership of organizations, reports individual scores by surgeon in the region where they practice. These measures consider such protocols as antibiotic starts and stops, temperature management, and even if body hair was properly removed from around the surgery site (to reduce the chance of infection). "Surgeons expect to continuously improve, so the data is very powerful," added Dr. Phillips.

Doug Weeks, Senior Vice President of Hospital Operations, notes the hospital has adopted information system and hands on strategies to improve the patient satisfaction component of the scores, also known as HCAHPS (Hospital Consumer Assessment of Healthcare Provider and Systems). Baptist employs daily employee "Huddles", an effective face-to-face tool in which everyone across all shifts in the organization receives the same information. Huddles are used to review the hospital's mission and values as well as quality and standards. Such focused mission and values repetition is a hallmark of high performance organizations.

Weeks said the hospital's electronic medical record is a vital tool in improving quality of care. Care points are incorporated and measured and these stats are available to nursing managers on a weekly basis. The hospital's data and trends are also reported upwards to the Board of Trustees. And a Joint Commission Conference Committee, which oversees the hospital's inspection readiness, review quality, HCAHPS and risk management issues (patient harm) in association with leaders of the medical staff in order to make recommendations to the Board.

Arkansas Surgical Hospital in Little Rock achieved 100 percent on quality measures last quarter by streamlining and hardwiring processes. Chief Clinical Officer Judy Jones said that their patients have a high awareness of the hospital's scores. For example they know that 93 percent say they would definitely recommend the hospital to friends and family and that their infection rate is less than one-tenth of the national average.

"We share our scores with everyone and we have a culture that allows an open forum for discussion and problem solving without finger-pointing," said Jones. "We hardwire processes and protocols and the physicians see the benefit of evidence-based medicine."

As an example she cited the work the staff has done on physician order sets. A patient's Foley catheter has to come out by post-op day two, so the order is placed in the physician's order sets to provide a double-check to ensure that it is done. Clinical note documentation templates also serve as a reminder for physicians to document the discontinuation or the reason for continuation of the catheter.

The effort adds up. According to the U.S. Department of Health and Human Services, which administers CMS, 30-day hospital readmission rates continued to decline in 2013. It also reported that infections, adverse drug events, and falls decreased by a combined nine percent from 2010 to 2013.[4] There are many coalitions and initiatives to improve quality outcomes and patient safety. The Institute for Healthcare Improvement launched its campaign to save 5 Million Lives, followed by its 10,000 Lives initiative. The Quest initiative organized by the hospital purchasing organization Premiere announced $9.1 billion savings in infection reductions among its participating 300 hospitals. Perhaps the best-known collation is

"When quality data first came out there was an attitude among doctors that this is really not my problem. There wasn't a belief in transparency, but that has changed. Now we get engagement from everyone, not just the great performers. Outcomes are the norm and we trust the data now."

–Eddie Phillips, MD, CMO, Baptist Medical Center

Eddie Phillips, MD

the nonprofit Leap Frog Group that formed in 2000 after a group of 34 corporate members, such as General Motors, General Electric, and Verizon grew increasingly alarmed at the healthcare cost to benefit ratio for their employees. These companies wanted to make a business case for rewarding healthcare providers in the marketplace for higher levels of quality and safety.[5]

According to Missy Danforth, Director of Hospital Ratings, about a third of hospitals in the U.S. voluntarily submit data to Leap Frog and all hospitals receive an annual safety letter grade (A-E) based on an extrapolation of public data.

"Some of the CMS measures are really valuable. The problem is 94 percent of hospitals are rated as not performing worse or better than the national average. This is not really helpful to quality or safety because it minimizes variation," said Danforth. "There is a lot of variation in these 94 percent and consumers have a right to know."

Danforth stressed that Leap Frog does not try to tell hospitals how to fix and improve, but rather they just identify the problems. "There are many clinical groups such as the American Medical Association, the American Nurses Association, and others with the expertise to change processes to improve outcomes and safety."

Danforth said that hospitals have made progress since 2000. "We've seen tremendous reduction in early deliveries and a drop in central line blood infections. No hospital is doing well on every measure, but we are getting there. I think patients are beginning to understand that judging a hospital is not just about in-room spas and steak dinners," she said. ■

SOURCES:
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UNFORTUNATELY, MORE THAN 80 MILLION AMERICANS, AND MOST ARKANSANS, HAVE LIMITED HEALTH LITERACY

Say What?

UAMS CENTER TACKLES HEALTH LITERACY

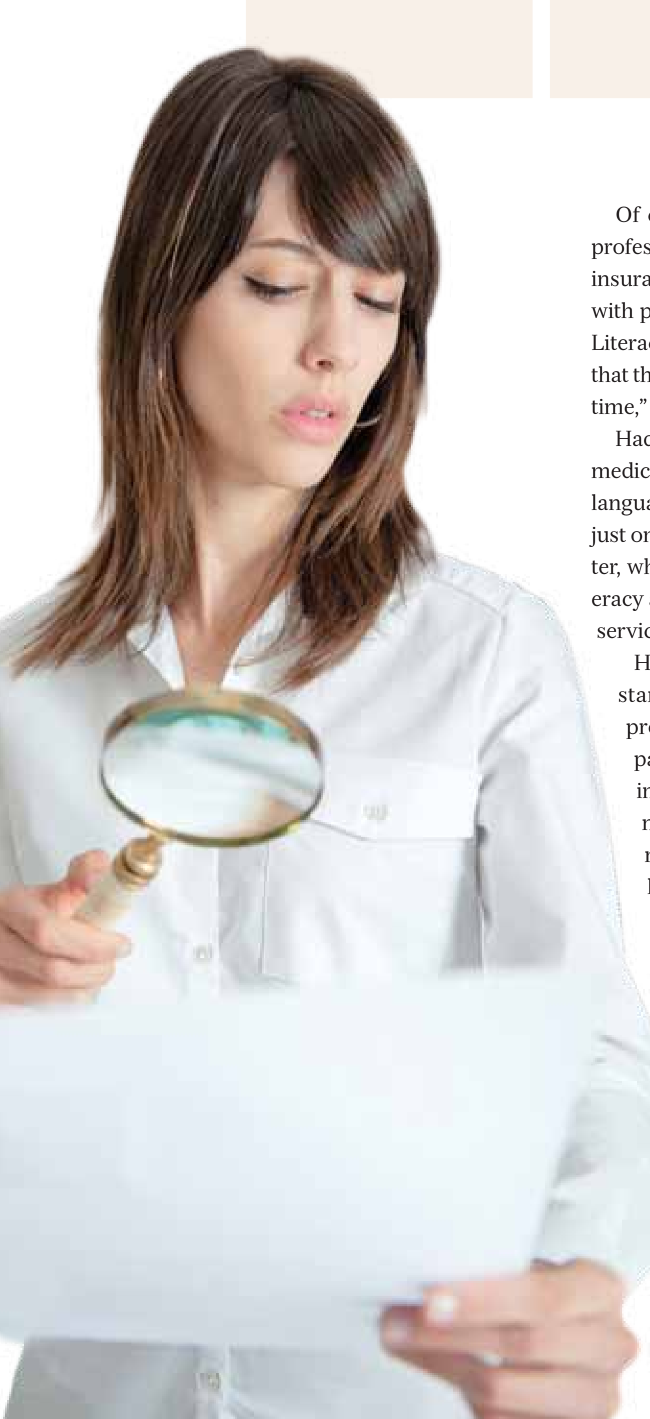
By **Kelly Taber**

Have you ever explained a diagnosis to a patient only to be met with a blank stare, almost as if you were speaking another language? Perhaps you are.

Provider-patient communication is not always as clear as it could be, and there are strategies for improved comprehension, according to Dr. Kristie Hadden, director of the newly-established University of Arkansas for Medical Sciences Center for Health Literacy.

Of course even those in the healthcare profession can get befuddled by a confusing insurance notice or the fine print provided with prescriptions.

KRISTIE HADDEN, MD



Of course even those in the healthcare profession can get befuddled by a confusing insurance notice or the fine print provided with prescriptions. At the Center for Health Literacy, staff members receive documents that they have trouble understanding "all the time," said Hadden.

Hadden and her staff translate an array of medical forms and written information into language for the average consumer. This is just one of the activities ongoing at the Center, whose mission is to increase health literacy across the state through research and service.

Health literacy – the ability to understand a health condition or a health provider's instructions – is crucial for patients receiving care and for preventing illness to stay healthy. Unfortunately, more than 80 million Americans, and most Arkansans, have limited health literacy.

Higher levels of education are associated with better health literacy, but Hadden is quick to point out that the complexity of the U.S. health system can boggle the mind of even the most knowledgeable expert.

Hadden receives documents that can require extensive research to interpret into layman's terms.

"We get information from specialty clinics that is very disease specific with a lot of medical jargon...and insurance information most people, including our well-trained staff, find very difficult to understand," she said.

The Center's staff also provides trainings to health professionals to make their directions easy for patients to understand during office visits and, most importantly, easy to implement when they are at home.

"Most providers really do want to be good communicators and they really do care about their patients. It's just a matter of getting everyone on the same page about what is easily understood," Hadden said.

She recommends these communication tactics for healthcare providers:

Demonstrate actions a patient is expected to perform at home. For example, rather than telling a patient what pills they need to take each day, a nurse or doctor can ask a patient to show his or her prescription regimen.

Avoid using numbers when possible. The ability to comprehend numbers is called numeracy. People often tune out when they hear numbers and percentages. For example, rather than say "an 84% chance," it's often more effective to tell a patient that something is "very likely" to occur.

Provide information as an illustration rather than text when possible. This may be especially important for the aging and elderly

Latrina Prince, Dr. Kristie Hadden, and Wendy Thompson with the Center for Health Literacy.

A STATE ACTION PLAN BASED ON THE NATIONAL ACTION PLAN TO IMPROVE HEALTH LITERACY IS AVAILABLE AT HTTP: //PHLA.NET/.

who struggle with vision, hearing and/or cognitive impairment.

Use simple language. For example, an often-confused term is hypertension. Providers are encouraged to use the everyday language of "high blood pressure" for patients with hypertension.

Break down a long list of instructions or information into small chunks. Once comprehension is achieved for a small number of items (no more than three), the provider can move on to additional information.

Don't ask a patient if he or she has any questions. The patient may feel too embarrassed to ask a question. Instead, to confirm understanding, health providers should ask patients to explain the information in their own words.

Written pamphlets and health information should be easy-to-read and kept at a sixth-grade reading level. Medical jargon should be avoided or, where necessary, defined with a plain language explanation.

Low health literacy creates higher healthcare costs and higher rates of disease and illness.

"Patients with lower health literacy are more likely to be admitted to hospitals and readmitted to hospitals, more likely to have chronic diseases, and less likely to seek preventive services, such as breast cancer screenings and flu shots," Hadden said.

The Center for Health Literacy is not the first state effort in these areas. For several years, the Arkansas Department of Health has worked to coordinate efforts through the Partnership for Health Literacy in Arkansas, said Cathy Flanagin, director of Health Communications and Marketing at the Arkansas Department of Health.

A state action plan based on the National Action Plan to Improve Health Literacy is available at http://phla.net/. This action plan includes seven goals developed by the Partnership for Health Literacy in Arkansas.

The Arkansas Department of Health has worked with the Center for Health Literacy on several initiatives, said Flanagin. "We are very excited about the creation of the Center and believe it will help increase efforts to improve health literacy throughout the state." ■

Health care you can *wear*

By **Carolyn Heneghan**

ARE YOU READY?

PHOTO: FLICKR: LOIC LE MEUR ON GOOGLE GLASS

Imagine wearing a curious-looking pair of glasses during a surgical procedure which allows you to see not only exactly what you are doing in your patient's body—through their skin and organs—but also information regarding their vitals projected just in front of your eyes. Picture a checkup where your patient uploads health information from a wristband that gives you a complete picture of their health since their last visit.

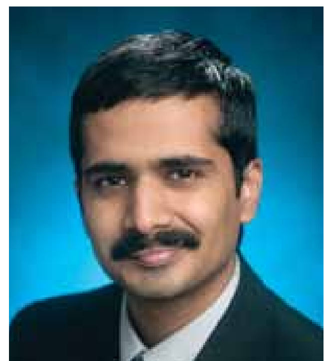
Imagine no more. Wearable technology for healthcare is here.

How Is Wearable Technology Being Used for Healthcare?

The year 2014 is said to be the year of wearable technology, and its ability to revolutionize healthcare for patients, doctors, and medical staff is being seen more strongly than ever.

For example, Phillips Healthcare has used Google Glass to devise a solution that enables doctors and hospital and clinic staff to have real-time access to a patient's status, vitals, and even electronic health records at all times.

Shiv K. Agarwal



Srikanth Vallurupalli

Wearable technology also allows patients to monitor their own health, such as heart rate, blood pressure, and blood sugar. iHealth introduced three such devices at CES 2014: the industry's first wearable ambulatory blood pressure monitor; a first-of-its-kind wearable wireless ambulatory electrocardiogram; and a wearable pulse oximeter.

Wearable technology has already been used extensively in the monitoring and treatment of diabetic patients. Genesis from Pancreum, for example, is a waterproof, Bluetooth-enabled, wearable artificial pancreas that acts as both an insulin delivery system and a way to continuously monitor the wearer's glucose levels. Other glucose monitoring systems, which are helpful for both the patient and the patient's doctor, are prevalent in the consumer market, not just in medical settings.

Known as the "father of augmented reality," Professor Steve Mann and his team at Eyetap have created a wearable computer in the form of glasses that capture high dynamic range photography, or images that cannot be seen by the human eye, in real time. While this was originally developed for welders at work, the medical implications of such a vision-improving device could be revolutionary for healthcare, particularly for that of the extremely hard of seeing or even the blind.

But these are just a few examples, and healthcare companies and researchers are finding many other innovative uses with innumerable devices now in the pipeline.

Wearable Healthcare Technology in Arkansas

While wearable technology in medical settings has not yet become prominent in local Little Rock hospitals, researchers at the University of Arkansas have developed some of these wearable healthcare products and methods which could become more widely used in the future. These involved products created by researchers as well as the strategic use of Google Glass, a wearable headset technology that employs augmented reality to display external information on the glasses' screen.

Engineers from the University of Arkansas, for example, have developed a wearable technology—sports bras for women and vests for men—that monitor various aspects of cardiac health and patient information. This information includes blood pressure, respiratory rate, body temperature, oxygen consumption, and some neural activity, and it can be transmitted in real time over a wireless network to inform the patient herself, her physician or a hospital.

In another instance, an interventional cardiologist from the University of Arkansas for Medical Sciences, Dr. Christian Assad-Kottner, wore Google Glass during surgery to digitally augment the surgical process by

connecting with Dr. Eudice Fontenot, a professional in PFO repair at Arkansas Children's Hospital. Via live streaming, Dr. Fontenot was able to provide real time recommendations for Dr. Assad-Kottner during the procedure. As a result, the operation combined physical clinical skills from within the hospital with the guidance of another medical professional located outside of the procedure room.

To improve graduate medical education and the ability of fellows and residents to learn and practice diagnostic and treatment techniques, researchers at University of Arkansas devised methods for using Google Glass as well. These researchers employed the device's various functions to connect trainees with supervisors who could walk them through procedures, review patient documents, and observe the trainees' interactions with the patients via live video and audio transmissions between the two parties. The study proved the effectiveness of wearable technology and its ability to aid fellows and residents in the learning process.

"Most of the complex and sick patients receive care in the tertiary hospitals which are mainly driven by residents and fellows," study researcher Shiv K. Agarwal says. "[Residents and fellows] need proper guidance and proctoring especially in their early formative years, and this technology will make it easier."

Another researcher for the study, Srikanth Vallurupalli, recognizes the potential benefits and issues of wearable technology in healthcare.

"Wearable technology has tremendous potential in making telemedicine more affordable and available," says Vallurupalli. "The most significant challenge is protecting patient privacy. Makers of wearable hardware and software should concentrate on data security to make inroads into healthcare. A 'walled off ecosystem' will have a greater chance of making hospitals adopt wearable technology."

"The most significant challenge is protecting patient privacy. Makers of wearable hardware and software should concentrate on data security to make inroads into healthcare. A 'walled off ecosystem' will have a greater chance of making hospitals adopt wearable technology."

— SRIKANTH VALLURUPALLI

While the security of patient data will be a hurdle for wearable technology researchers and developers to overcome, the possibilities that the healthcare industry faces in the wake of these devices and software are exciting for both benefactors and producers of wearable technology.

Himakara Pieris

Himakara Pieris is founder and CEO of myMD, an app that connects patients and doctors via a patient's mobile phone and third party wearable devices that allow both parties to proactively manage patient health. He also acknowledges the significant impact that wearable technology will have on the present and future of healthcare.

"Wearable technology is going to play a critical role in early diagnosis and prevention, reducing the need for secondary and tertiary care," Pieris says. "I think it is in the best interest of all stakeholders, including patients, physicians, and insurers, to embrace wearable technology in healthcare."

As Little Rock and the rest of the medical world more fully embrace wearable technologies, healthcare will likely see dramatic changes in the day-to-day monitoring and care of patients and their interactions with their healthcare providers. ■

Joint Commission, Local Hospitals Take Closer Look at Fall Prevention

fall focus

By **Yvonne Dick**

Approximately 11,000 fatal patient falls occur in U.S. hospitals annually. One in three seniors will experience a fall at least once. 30-35% of patient falls cause injury, averaging 6.3 extra days in the hospital. To find out how to prevent falls, The Joint Commission Center for Transforming Healthcare started the “Preventing Falls with Injury” project.

The goal was to reduce the rate of patients injured in falls by 50% and all falls by 25%. Project hospitals were Barnes-Jewish Hospital, Missouri Baylor Health System, Texas Fairview Health Services, Minnesota Kaiser Permanente, California Memorial Hermann Healthcare System, Texas Wake Forest Baptist Medical Center, North Carolina, and Wentworth-Douglass Hospital, New Hampshire. The program used the Robust Process Improvement Scale. RPI is a fact-based, systematic, and data-driven problem-solving methodology which uses ideas and tools from LEAN, Six Sigma, and Change Management.

Participating hospitals were able to significantly reduce the total number of falls and falls with injury. Staff awareness of risk factors and patient participation were key to the study. During the study hospitals used a validated fall risk assessment tool, involved patients and their families in fall safety awareness and the fall safety program at the time of admission, scheduled trips to the bathroom, reminded patients frequently to always ask for help walking, encouraged a culture among the staff of fall safety along with the notion of ‘no patient walks alone’, and added hourly rounding.

The Commission found that after 18 months, the number of patients injured by fall was reduced 62 percent, and the number of patient falls decreased 35 percent among the participating organizations and hospitals. The Center estimates that if their program is put in place in a typical 200-bed hospital, the number of patients injured in a fall could be reduced from 117 to 45, and save approximately $1 million annually through fall prevention efforts.

“Patient falls are a serious problem that have received a great deal of attention, yet defy easy solutions,” says Erin DuPree, MD, Vice President and Chief Medical Officer, Joint Commission Center for Transforming Healthcare. “These seven organizations are leading the way in developing strategies that keep

patients safer. By using these approaches to determine the specific causes of falls and targeting interventions accordingly, real and substantial improvement can be achieved."

The Joint Commission Center for Transforming Healthcare released The Targeted Solutions Tool® (TST) for preventing falls with injury. Currently in development for release in 2015, parts of the interactive software can currently be accessed by accredited organizations using their secure Joint Commission Connect extranet.

Meanwhile, in May of 2014 Baptist Health Medical Center offered Arkansas Innovative Performance Program's fall prevention and quality sleep course. Led by Sue Ann Guildermann, RN, Director of Education at Empira, the target audience was long-term care staff. A two subject course, the day addressed methods leading to fewer resident falls, as well as the importance of avoiding sleep disturbance in patients.

DURING THE TRAINING, STUDENTS LEARNED TO IDENTIFY MAIN CAUSES OF PATIENT FALLS – PHYSIOLOGY, MEDICATION, PHYSICAL BARRIERS.

During the training, students learned to identify main causes of patient falls–physiology, medication, physical barriers. The course also provided an overview of the etiology of sleep and wake cycles in the brain. Training materials given to students provided ways that residents might be exposed to greater fall-prevention risk, as well as how to allow patients to sleep throughout the night undisturbed, without negative outcomes.

Guildermann says, "We bring human beings into a strange environment–the nursing home–and then we start having alarms go off all through the night and the day. They don't know what it is, but they do know one thing: Get out! Even our most confused resident knows, 'if it's an alarm, I need to get out', and during that process they fall."

A study published by French researchers Fabienne El-Khoury and associates analyzed 17 studies of more than 4,000 participants regarding fall prevention exercises. Among their conclusions, published online in bmj.com and covered in *Healthday News*, October 29, 2013, "Fall-related injuries are common among seniors and a major cause of long-term pain and disability. They also increase the risk of having to go to a nursing home and have a high economic cost."

Exercise programs reviewed focused on gait, balance, strength, and functional training – workouts which would help people to be flexible and able to perform normal daily activities. Tai Chi was included in two of the studies. Balance training was a key part of

Exercise programs reviewed focused on gait, balance, strength, and functional training – workouts which would help people to be flexible and able to perform normal daily activities.

the programs most successful in fall prevention. The study authors noted that, " reducing the risk of falling and improving protective responses during a fall may be an important and feasible means of preventing fractures and other serious injuries in the elderly."

At CHI St Vincent in Little Rock there are several patient-centered programs for prevention and faster medical recovery. These include Safety First (a goal of zero events of preventable harm by 2020); Evidence-based Practices (observing what constitutes a success and repeating it, including discovering what helps patients in the fall prevention programming); and One Care (a system where each patient has one transferable, accessible electronic medical record). At the St Vincent Longevity Center fall prevention/treatment and balance programs are available to the community. On the St Vincent website the tab Health Library provides a variety of articles on fall prevention for various age groups and tips to be safe at home.

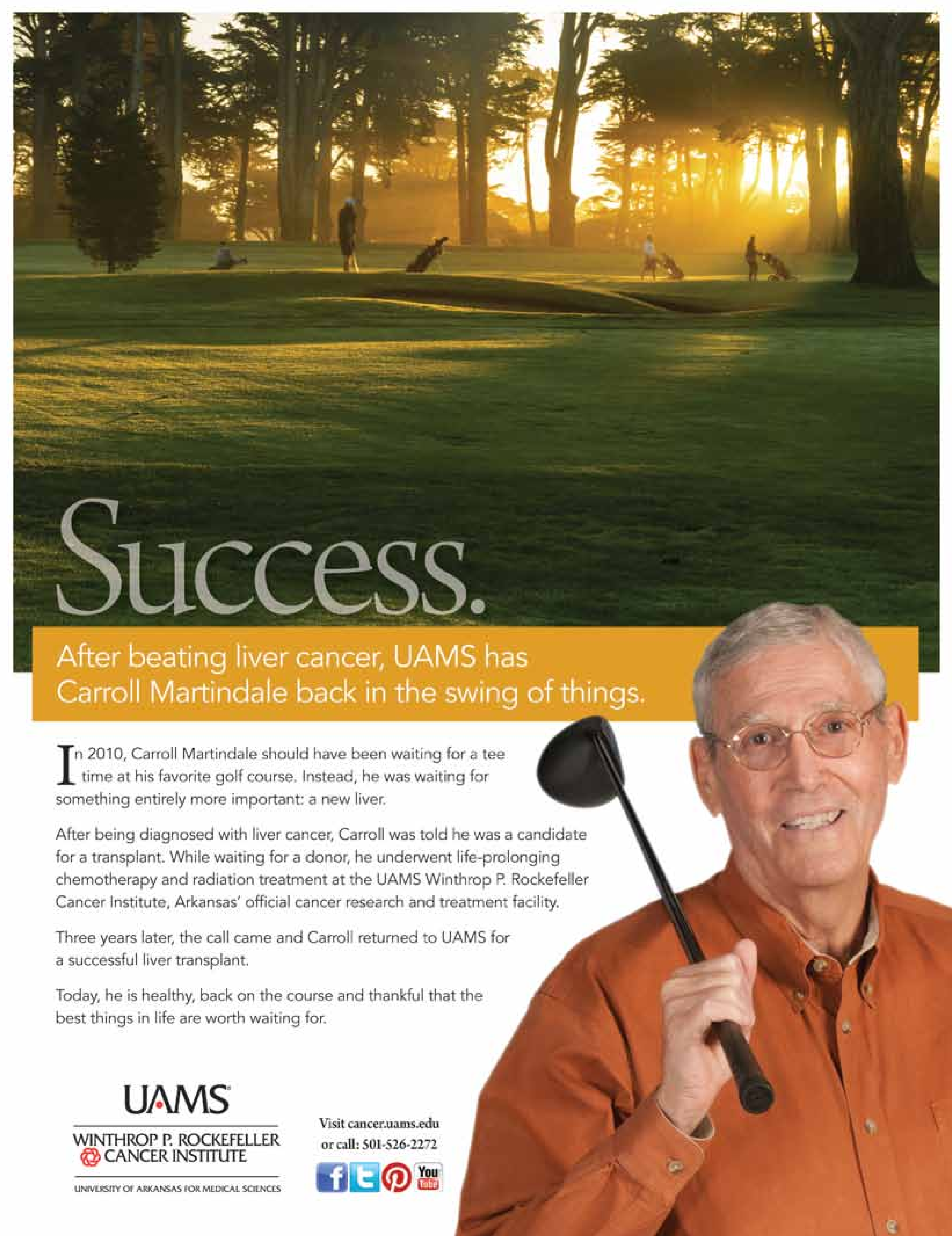
At the University of Arkansas for Medical Sciences Medical Center, Clinical Services Manager Amy Hester, RN, and Advanced Practice Partner Dees Davis, RN, worked on a fall-prevention research project for nearly a year and a half. Says Hester, "As with many hospitals serving an aging population, or with an increased neurological patient population, we had a lot of work to do to prevent falls. It's a myth that only seniors fall."

"Back in 2008 while we were still in the older hospital, we had our Fall Committee looking at single fall interventions. That's when we saw some benefits to assessing falls. Using a modified SCIE Risk Assessment wasn't quite enough for our situations. So we developed our own tool," says Davis. After researching for a year and a half, the result was the Hester-Davis Scale.

In January of 2010 they put the Hester-Davis Scale into place. Now copyrighted for use in other hospitals, the scale started small but had similar success to the TST project. The Hester-Davis Scale is a risk-assessment tool that identifies patients most likely to fall, and, more specifically, the reason for the fall risk and appropriate interventions for the nurse/patient/family to implement. The scale's results spoke volumes. There was a 20% decrease in falls hospital-wide and a 40% decrease in injuries after the first six months.

"It spread so fast we couldn't keep track of all the facilities using it. We know of organizations in 20 states who've made inquiries directly from us, and there are others who've adopted it based on the experiences of these facilities without contacting us," says Davis.

While falls occur every day in normal patient life at home (75% of falls happen there), with new Fall Prevention measures such as the TST, rehabilitation and exercise programs, seminars such as the AIPP's fall prevention, and the Hester-Davis scale, healthcare practitioners now have a variety of ways to help patients keep on the mend and avoid falling. By 2016, Hester and Davis estimate their program will have 'touched' the lives of 65 million people. Fall prevention actions and research will be there to support those who need it and prevent every medical worker's dreaded scenario–the fall. That, according to Hester and Davis, is worth everything. ■



Success.
After beating liver cancer, UAMS has
Carroll Martindale back in the swing of things.
In 2010, Carroll Martindale should have been waiting for a tee time at his favorite golf course. Instead, he was waiting for something entirely more important: a new liver.
After being diagnosed with liver cancer, Carroll was told he was a candidate for a transplant. While waiting for a donor, he underwent life-prolonging chemotherapy and radiation treatment at the UAMS Winthrop P. Rockefeller Cancer Institute, Arkansas' official cancer research and treatment facility.
Three years later, the call came and Carroll returned to UAMS for a successful liver transplant.
Today, he is healthy, back on the course and thankful that the best things in life are worth waiting for.
UAMS
WINTHROP P. ROCKEFELLER
CANCER INSTITUTE
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES
Visit cancer.uams.edu
or call: 501-526-2272

UCA PRESIDENT TAKES ALS CHALLENGE

University of Central Arkansas President Tom Courtway got a bucket of iced water dumped on him by Director of Special University Projects/Community Affairs T.J. Johnston and UCA Athletic Director Brad Teague got dunked by his children while the two took part in the ALS ice bucket challenge at Estes Stadium.

The challenge involves participants having a bucket of iced water poured over their head and then challenging others to make a donation to fight ALS. Courtway did the challenge in honor of John Stanton, a Conway businessman and public figure who died in 2008 from the disease, while Teague participated in memory of James "Skeeter" Banks of Southaven, MS, a baseball teammate of his while in college.

(L-R) **Brad Teague and Tom Courtway** | Photo Courtesy of UCA/Mike Kemp

HEALTHCARE BRIEFS

STATE

Arkansas Sees Sharpest Drop in Uninsured Rate

A recent Gallup report shows that Arkansas outpaced the rest of the country in reducing the rate of uninsured residents during the first six months of 2014. Arkansas's uninsured rate fell from 22.5% at the end of 2013 to 12.4% midway through 2014. This means that approximately 45% of Arkansans who did not have health coverage at the beginning of the year are now insured.

In 2013, Arkansas ranked next to last among states for its uninsured rate, with only Texas having a higher rate of uninsured residents. Six months into 2014, Arkansas had surpassed half the country, and was tied for 22nd with New Hampshire.

TMF Health Quality Institute Wins Contract

TMF Health Quality Institute has secured the five-year Quality Innovation Network Quality Improvement Organization (QIN-QIO) contract with the Centers for Medicare & Medicaid Services (CMS) for Texas, Arkansas, Missouri, and Oklahoma.

In May 2014, CMS announced changes to the structure of its QIO program among which include a multi-state regional approach to replace state-specific QIOs for quality improvement work, designated the QIN-QIO Program.

TMF has built a strong quality improvement team throughout the multi-state region, subcontracting with longtime, successful quality improvement entities, Arkansas Foundation for Medical Care (AFMC) and Primaris.

The QIN-QIO contract aligns with the Department of Health and Human Services' National Quality Strategy to accomplish better care, better health for people and communities, and affordable care through improvements.

The contract focuses on several key issues:

- Improving cardiac health and reducing cardiac health care disparities
- Reducing disparities in diabetes care
- Improving prevention efforts through meaningful use of health information technology
- Reducing infections in hospitals
- Reducing harm in nursing homes
- Assisting physicians and hospitals with quality reporting
- Helping communities improve the coordination of healthcare for patients to help reduce unnecessary hospital readmissions

TMF, along with AFMC and Primaris, will provide targeted technical assistance and will engage providers and stakeholders in improvement initiatives through numerous Learning and Action Networks. The networks serve as information hubs to monitor data, engage relevant organizations, facilitate learning and sharing of best practices, reduce disparities, and elevate the voice of the patient.

DHS Policy and Planning Director Tapped for Fellowship

Marquita Little

Marquita Little, Policy and Planning Director for the Arkansas Department of Human Services (DHS), is among 48 policymakers from across the nation selected to be a Toll Fellow for the Class of 2014.

The Toll Fellowship Program is one of the nation's most prestigious leadership development programs for state government officials. It is sponsored annually by the Council of State Governments (CSG). The program brings policy leaders together for a six-day intellectual boot camp that features dynamic speakers, and sessions designed to stimulate personal assessment and growth, while providing networking and relationship-building opportunities. This year's session will be held in September in Lexington, Kentucky.

Newly Insured Have Positive View of ACA

Despite challenges faced during the enrollment process for obtaining health insurance through the Affordable Care Act, nearly every newly insured person interviewed for a report released in June said having health insurance has been a positive development in their lives.

Fifteen students and three instructors in the University of Arkansas for Medical Sciences (UAMS) Fay W. Boozman College of Public Health in the spring conducted a project, Voices of the Newly Insured, interviewing 29 people who sought health insurance through the new Arkansas Insurance Marketplace and the Arkansas Private Option.

Voices of the Newly Insured describes interview themes and includes 11 personal stories of individuals who recently acquired health insurance because of the Affordable Care Act. To read a copy of the report, go to: http://publichealth.uams.edu/files/2012/06/Voices-of-the-Newly-Insured.pdf .

Among the study's findings were:

- Nearly all of the interviewees reported challenges accessing health care before the implementation of the Affordable Care Act.
- Their difficulties in the enrollment process varied with electronic, paper and over-the-phone applications, but more than half did not report problems.
- One-third of the participants did not fully understand all the details of their health insurance plans.
- All individuals interviewed described feelings of relief knowing they had coverage.
- About half of the individuals expressed gratitude that their insurance plans had no cost-sharing components.

Campaign Returns to Help Arkansans Quit Smoking

Continuing with the success of last year's landmark national tobacco education campaign, the Centers for Disease Control and Prevention (CDC) is airing a another series of ads in 2014 featuring real people who are living with the effects of smoking-related diseases. The newest ads in the "Tips from Former Smokers" campaign tell the story of how real people's lives were changed forever due to their smoking. In Arkansas, 5,100 people die every year from smoking-related diseases. The new ads

will air between July 7 and September 7.

The ads feature smoking-related health conditions that people do not commonly associate with cigarette use–including including gum disease, pre-term birth, and complications associated with HIV–and continue to emphasize more common conditions, like cancer. They encourage smokers to call the Tobacco Quitline at 1-800-QUIT NOW, a toll-free number to access free quitting support across the country, or visit www.cdc.gov/tips to view the personal stories from the campaign.

HHS Supports State Home Visiting Programs

Health and Human Services Secretary Sylvia M. Burwell announced $106.7 million in FY 2014 grant awards to 46 states, the District of Columbia, and five jurisdictions as part of the Maternal, Infant, and Early Childhood Home Visiting Program (Home Visiting Program) established by the Affordable Care Act. The Arkansas Department of Health was awarded $1,269,015.

These funds will allow states to continue and expand voluntary, evidence-based home visiting services to women during pregnancy and to parents with young children up to age five.

For more information on HRSA's Home Visiting Program, visit http://mchb.hrsa.gov/programs/homevisiting.

Beware of Mosquitoes on Caribbean Travels

The Arkansas Department of Health (ADH) warns individuals and groups traveling to the Caribbean to take steps to protect themselves from mosquito bites. In December 2013, the World Health Organization (WHO) reported local transmission of chikungunya (pronunciation: chik-en-gun-ya) in Saint Martin. Local transmission means that mosquitoes in the area have been infected with chikungunya and are spreading it to people. This is the first time that local transmission of chikungunya has been reported in the Americas.

Local transmission of chikungunya is now being reported in other countries in the Caribbean. Travelers who go to these islands in the Caribbean are at risk of getting chikungunya. In addition, travelers to Africa, Asia, and islands in the Indian Ocean and Western Pacific are also at risk, as the virus is present in many of these areas. The mosquito that carries chikungunya virus can bite during the day and night, both indoors and outdoors.

Smokeless Tobacco Use Rises Among Arkansas Youth

According to recently released Centers for Disease Control and Prevention (CDC) Youth Risk Behavior Survey (YRBS) data, Arkansas ranks second in the nation for smokeless tobacco use among youth. In 2013, 14.8 percent of Arkansas youth used smokeless tobacco; this rate is an increase from the 2011 rate of 11.6 percent and well above the national rate of 8.8 percent.

These new statistics, along with information about the impact of smokeless tobacco on athletes, reinforce the need for tobacco control advocates to intensify efforts to prevent initiation of smokeless tobacco use among youth and encourage current users to quit.

Current tobacco users interested in quitting can call the Arkansas Tobacco Quitline at 1-800-QUIT-NOW or visit stampoutsmoking.com for more information.

DHS Division Director Jones to Retire

The Department of Human Services (DHS) Division of County Operations Director Joni Jones retired Aug. 31, ending a career with the agency that spanned more than three decades and included successful efforts to modernize and automate much of the casework for public assistance programs statewide.

In 2001, Jones was named director of county operations, which is responsible for all 86 DHS county offices, commodity distribution and applications for Medicaid and other public assistance.

DCO Assistant Director Delia Anderson will be the division's new director. Anderson, 49, currently manages the DCO Office of Community Services, which distributes and monitors federal funding for community action agencies and other providers statewide. She has been with DHS for eight years.

Lynda Beth Milligan, MD, FAAFP, CPE, CHCQM

Restorative Dental Benefits Subject to Waiting Period

The Arkansas Department of Health announced that restorative dental benefits for Health Care Independence Program beneficiaries will not be available as of January 1, 2015.

Currently, only one plan, Ambetter + Adult Vision + Adult Dental, offers restorative benefits, and those are subject to a six-month waiting period. Therefore, anyone who signed up for that plan after July 1, 2014, will not have access to those benefits.

Milligan Named AFMC Medical Director

The Arkansas Foundation for Medical Care (AFMC) has named Lynda Beth Milligan, MD, FAAFP, CPE, CHCQM, vice president and medical director. Milligan replaces retiring medical director Michael Moody, MD. Milligan was previously associate medical director for reviews for AFMC.

Milligan received her medical degree from the University of Arkansas for Medical Sciences, where she also completed a family medicine internship and residency. She is board certified by the American Academy of Family Physicians and the American Board of Quality Assurance and Utilization Review Physicians, Health Care Quality and Management. In addition to her work at AFMC, Milligan is a family practice physician at Saline Med-Peds clinic in Benton and volunteers her services at Esperanza Hope, a clinic that services the area's Hispanic community.

Moody, of Salem, Ark., has served as AFMC medical director since 1996. He plans to continue his medical practice in Salem and will also serve as a consultant for AFMC.

HEALTHCAREBRIEFS

Daniel Knight, MD

Knight to Lead Arkansas Academy of Family Physicians

Daniel Knight, MD, Garnett Chair and chair of the Department of Family and Preventive Medicine at the University of Arkansas for Medical Sciences (UAMS), has been elected president of the Arkansas Academy of Family Physicians. He was installed at the 67th president of the organization by Robert Wergin, MD, during its annual meeting.

He has been member of the organization since 1985. He has served as a board member, secretary and vice president. Knight is also a member of the American Academy of Family Physicians.

Knight graduated from medical school at UAMS in 1985. He completed his residency at the UAMS Department of Family and Community Medicine in 1988. Knight served as residency program director for the department for 11 years. He is board certified by the American Board of Family Practice.

LOCAL

Franklin Wins Arkansas Mutual Medical Student Award

Sarah Franklin of Gurdon has been named the first recipient of the Arkansas Mutual Medical Student Award, a scholarship for third-year medical students at the University of Arkansas for Medical Sciences (UAMS) who want to practice primary care in rural Arkansas.

The $10,000 scholarship was funded by the nonprofit Arkansas Mutual Insurance Co. in partnership with the UAMS College of Medicine to encourage more medical students to enter primary care fields such as family practice and general internal medicine and to practice in rural Arkansas where access to physicians is limited.

Portions of all of 52 of Arkansas' 75 counties have been designated as federal Primary Care Health Professional Shortage Areas. Approximately 44 percent of Arkansans live in rural areas. Primary care physician shortages are projected to increase substantially in the years ahead as the state's population continues to age and require more medical care, and as more Arkansans, newly insured as a result of health system reform, seek primary care services.

"Arkansas Mutual was very pleased to make this scholarship possible," said Corey Little, CEO. "The scholarship's focus on rural health care is especially important today and reflects our company's mission not only to protect and serve the physicians of the state, but also to contribute to a healthier Arkansas."

Franklin grew up in Benton and attended Brigham Young University in Provo, Utah, prior to medical school. She and her husband have lived in his hometown of Gurdon, southwest of Arkadelphia in Clark County, for the past several years when not in Little Rock for school.

Franklin has "shadowed" several physicians on clinical internships in Arkadelphia including John Elkins, MD, who delivered both of her children. "I want to practice family medicine and have additional training in obstetrics so that I can deliver a full spectrum of care to my patients," she said.

The College of Medicine has worked with partners such as Arkansas Mutual to increase scholarships for medical students. The high cost of medical school and the burden of educational debt that most medical students face when entering residency can be a factor in choosing higher-paying specialties instead of primary care. The average medical school debt of the 2014 UAMS graduates with educational debt is $160,244.

Scholarship recipient Sarah Franklin (seated) with (from left) Tom South, UAMS assistant dean for medical student admissions, Tom Robinson, MD, of Arkansas Mutual Insurance Co., and Arkansas Mutual CEO Corey Little.

Researchers Track Single Circulating Tumor Cells

Researchers from University of Arkansas for Medical Sciences (UAMS) and Albert Einstein College of Medicine in New York have developed a new technological approach for tracking individual circulating tumor cells (CTCs) in the bloodstream, helping researchers identify the pathways of single cancer cells inside the body and that holds the promise to prevent cancer from spreading.

"The approach may give oncologists a method to track individual CTCs and distinguish the behavior of metastatically aggressive CTCs from other ones. We hope, this knowledge will lead to development of new therapeutic approaches to target only dangerous CTCs, and, eventually, to intervene and stop cancer more effectively," said Ekaterina Galanzha, MD, PhD, an associate research professor in the

UAMS College of Medicine's Department of Otolaryngology, Head and Neck Surgery.

The findings of Galanzha as a leader of this research were recently published in *Chemistry & Biology*. UAMS team includes also Vladimir Zharov, PhD, D.Sc., senior scientist in the UAMS Winthrop P. Rockefeller Cancer Research Institute, and Dmitry Nedosekin, PhD, UAMS College of Medicine research associate in the UA.

Bank of America Gift Goes for Diversity Outreach

A $22,000 donation received from the Bank of America Charitable Foundation will support outreach programs at UAMS to help recruit and retain minority students to healthcare fields. For the past three years, the Bank of America Charitable Foundation has donated money to support the UAMS Center for Diversity Affairs (CDA). The $22,000 donation will help support CDA outreach programs for undergraduate and K-12 academic enrichment programs.

Jansen Chosen for Leadership Role at UAMS

Longtime family medicine physician Mark Jansen, MD, has been selected as primary care medical director for the Center for Healthcare Enhancement and Development at the University of Arkansas for Medical Sciences (UAMS).

Jansen, who practiced for 30 years in Arkadelphia before joining UAMS in 2013, also treats patients and trains residents through the Department of Family and Preventive Medicine. His special interests include dermatological procedures, primary care endoscopy, and preventive care. He is a 1981 graduate of UAMS and finished his family medicine residency at the University of Oklahoma, Tulsa Medical College in 1984.

Pulmonology Associates Welcomes Dr. Chinn

Dr. Albert Jones Chinn has joined Dr. Mushtaq Ahmad and the staff at Pulmonology Associates of Hot Springs. Board certified in internal and pulmonary medicine, Dr. Chinn is scheduling new patients, and began seeing patients in both the clinic and hospital settings in August.

Dr. Chinn is a member of the medical staff at National Park Medical Center where he is also providing critical care coverage to their ICU and CCU.

UAMS College of Medicine Second Most Popular

The University of Arkansas for Medical Sciences (UAMS) ranks second nationally among medical schools in the percentage of first-year students who are accepted and ultimately choose to enroll, according to *U.S. News and World Report*.

In 2013, the school enrolled 171 of the 205 first-year students it accepted, for a yield rate of 83.4 percent. The national average yield, according to the report, is 52.8 percent.

Marion County Woman Pleads Guilty to Fraud

A Marion County woman has pleaded guilty to felony Medicaid fraud for billing the state's Medicaid program for services she did not provide.

Amanda Coker, 36, of Yellville was convicted in Pulaski County Circuit Court on one count of Medicaid Fraud, a Class B felony. Special Circuit Judge John Plegge sentenced Coker to five years of probation. She was ordered to pay a fine of $10,357.95 and restitution of $3,452.65.

Coker was arrested last year after an investigation by the Attorney General's Medicaid Fraud Control Unit.

Coker fraudulently sought Medicaid reimbursement for personal-care services that she claimed to have provided to a Medicaid beneficiary in mid-2011. Coker's former housemate told an investigator with the Attorney General's Office that Coker could not have rendered the services since she did not have a means of transportation at that time.

Although Coker worked as an attendant to a Medicaid beneficiary for just a few days, she billed the Medicaid program over a period of two months.

To report suspected Medicaid fraud or abuse or neglect in nursing homes, call the Attorney General's Medicaid Fraud Control Unit hotline at (866) 810-0016 or visit www.ArkansasAG.gov.

16 Education Hours Available for Physicians

Family physicians may receive up to 16 hours of continuing education at the 18th Annual Family Medicine Update to be held Oct. 3 and 4 at the University of Arkansas for Medical Sciences (UAMS). The two-day conference is sponsored by the UAMS Department of Family and Preventive Medicine, CME division. It will be held at the Jackson T. Stephens Spine & Neurosciences Institute on the UAMS campus.

The conference features a wide range of family practice topics such as pain management, anemia, medical dermatology, ADHD in children, antipsychotics and benzodiazepines, diabetes, vaccines, and testosterone replacement. Harvey Makadon, clinical professor of medicine at Harvard Medical School, will speak on "Providing Optimal Care to LGBT Patients: What Clinicians Need to Know."

The early-bird rate for the conference is $259 ending Sept. 10. Standard registration will begin Sept.11 at $309. To register and see the complete agenda, go to cme.uams.edu or call 501-526-5439.

UCA Dietetic Interns Research Arkansas Communities

The University of Central Arkansas Dietetic Internship Program is collaborating with the Arkansas Coalition for Obesity Prevention's Growing Healthy Communities to provide health assessments in 20 Arkansas communities.

Through the internship, students use critical thinking skills to identify strengths, gaps, and opportunities in their selected communities.

The information gathered by the interns will be presented after they complete their internship. The communities are invited to attend the presentation and have access to a copy of the student's final report.

The assessments provide communities with the opportunity to highlight strengths and provide strategies to improve other areas.

Dr. Nina Roofe, Dietetic Internship Program Director, said, "It's a 'win-win' for our students as well as for ArCOP and the communities involved in the program."

Ten interns are selected each academic year.

Interns earn their post-baccalaureate degree and complete the dietetic internship in 15 months.

The current interns and their selected Growing Healthy Community are as follows:

Rebecca Blaylock- Perry County
Angela Bradshaw- City of Batesville
Candace Casebier- Searcy County
Hayley Chappell- Woodruff County
Ashley Cornett- City of Conway
Alicia Courtway- City of Monticello
Caroline Fridell- City of Maumelle
Aubree Fry- City of Harrison
Amanda Gentry- City of Little Rock's University of Arkansas at Little Rock's University District
Robin Gipson- Saline County
Brenda Green- Monroe County
Chris Henson- City of Wooster
Mandy Hines- City of Little Rock's South Main Street Community
Miranda Lytle- City of Hot Springs
Erick McCarthy- City of Greenbrier
TJ Mirji- City of North Little Rock
Lyndsay Myers- City of Bentonville
Rachel Sanders- City of Bryant
Daniela Utrera- City of Fayetteville
Erica Watson- City of Little Rock's Arkansas People First Community

UAMS Receives Funds to Train Primary Care Providers

Health and Human Services (HHS) Secretary Sylvia Mathews Burwell announced $83.4 million in Affordable Care Act funding to support primary care residency programs in 60 Teaching Health Centers across the nation. The UAMS Family Medicine program in Little Rock received an award of $900,000.

Nationally, the funding will help train more than 550 residents during the 2014-2015 academic year, increasing the number of residents trained in the previous academic year by more than 200 and helping to increase access to health care in communities across the country.

Created by the Affordable Care Act, the Teaching Health Center Program expands residency training in community-based settings. Residents will be trained in family medicine, internal medicine, pediatrics, obstetrics and gynecology, psychiatry, geriatrics, and general dentistry.

Clot Buster Device Helps in Stroke Treatment

A new device developed by a physician at the University of Arkansas for Medical Sciences (UAMS) and a researcher at the University of Arkansas at Little Rock (UALR) could soon be available to treat stroke more effectively. The ClotBust ER® fits on the head like a halo and delivers therapy to quickly bust clots that cause stroke.

It was developed by William Culp, MD, professor of radiology, surgery and neurology and vice chairman of research at UAMS, and Doug Wilson, assistant director at the Graduate Institute of Technology at UALR.

Culp has spent many years studying therapy for stroke. One element of Culp's work included using ultrasound (high-frequency sound waves) in combination with the clot-busting drug tissue plasminogen activator (t-PA).

While looking into the treatment to dissolve clots in blood vessels, Culp realized one problem is getting the ultrasound to operate through the skull. Ultrasound can be delivered anywhere in a patient's body unless the waves hit something hard like bone or something very soft, like air.

Culp received an $8,000 grant from UAMS that provided him with the materials he needed to experiment. Wilson and Culp completed their first patent for "ultrasound for augmented clot lysis" in 2005. The patent was licensed in 2006 and has been in development by Cerevast Therapeutics.

The ClotBust ER® has 16 transducers scattered around the inside – designed to line up with the thin points in the skull: the temples and the foramen magnum in the base of the skull. This allows the ultrasound waves to move through the brain without interruption. After the patient is administered an IV containing t-PA, the circular device is placed onto the patient's head like a sports visor or halo.

Now in a Phase Three human trial, the ClotBust ER® has been tested in more than 300 patients. None of the results have come back with significant adverse effects. Since the trial periods began, 66 other university sites have signed up to be included in the testing. The device will also soon be available at some sites of the statewide stroke network called AR SAVES while it is in trial.

Two UAMS Medical Students Receive Scholarships

Two senior medical students at the University of Arkansas for Medical Sciences (UAMS) have been awarded $20,000 scholarships earmarked for future physicians who are committed to improving access to primary care for Arkansans.

Andrew Briggler, from Hattieville, and Nathan Schandevel, from Paragould, are this year's recipients of the Arkansas Blue Cross and Blue Shield Primary Care Scholarship, which has been presented to two UAMS College of Medicine juniors or seniors annually since 2012 through a $1 million endowment grant from the state's largest insurer in partnership with UAMS.

Angel Eye Installs Cameras in DFW Area

Angel Eye Camera Systems, a company established in 2013 with support from the University of Arkansas for Medical Sciences (UAMS) BioVentures, recently completed the installation of 79 camera systems in the neonatal intensive care units (NICU) at Texas Health Presbyterian Hospital Dallas, Texas Health Presbyterian HospitalPlano, and at Texas Health Harris Methodist Hospital Fort Worth.

Complete with audio, parents can see and talk to their baby anytime, day or night from their mobile phone or computer.

UAMS Names Oral Health Clinic for Delta Dental

The University of Arkansas for Medical Sciences (UAMS) has unveiled a new name for its oral health clinic — the Delta Dental of Arkansas Foundation Oral Health Clinic — in celebration of the foundation's gift to help build the facility for hosting dental education while expanding access to dental care.

The foundation announced in January 2013 a pledge of $2 million toward the clinic that had just opened on the UAMS campus. The clinic, a part of the Center for Dental Education in the UAMS College of Health Professions, will host a postgraduate dental residency program under development.

The dental residency program is on schedule

to welcome its first dental residents in July 2015. The clinic, where two faculty dentists now provide comprehensive dental care, also began hosting senior dental students from the University of Tennessee College of Dentistry for clinical rotations in early 2014. New groups of fourth-year students will begin arriving in August with the start of the fall semester for two weeks of clinical experiences with patients under supervision of faculty dentists.

The 7,500-square-foot clinic includes nine rooms for general dental exams (with one more to be finished by the end of 2014), one sedation suite for more complex procedures, and two overflow exam rooms shared with the adjacent clinic for the college's dental hygiene program.

Former Nurse Arrested for Theft of Medication

A Saline County woman accused of stealing prescription narcotics intended for residents at the healthcare facility where she worked was arrested following an investigation by the Attorney General's Medicaid Fraud Control Unit.

Tasha Lenard, 24, of Bryant, was arrested on two counts of obtaining a controlled substance by fraud or theft, a Class D felony. She was released from the Saline County Detention Center on $10,000 bond.

Lenard formerly worked as a licensed practical nurse at the Department of Human Services' Arkansas Health Center in Benton. She is accused of taking for her own personal use at least two dosages of morphine and 10 methadone tablets that had been prescribed for two residents of the facility.

Lenard has voluntarily surrendered her nursing license.

McDaniel Files Suit Against Chiropractic "Runners"

Attorney General Dustin McDaniel filed a consumer-protection lawsuit against Roger D. Pleasant, his employees Rogerick Pleasant, James "Jimmy" Hinton and Brian Hinton, and the entities Information and Discovery Inc., PSG and Investigation LLC, Accident Claim Service LLC, Physician First Marketing Group LLC and Network Collision Group LLC.

The defendants are accused of using deception and harassing tactics in their attempts to convince accident victims to visit a chiropractor. Roger Pleasant and his employees are known as chiropractic "runners." They collect consumer information from accident reports, and then solicit business on behalf of the chiropractors who pay them if the consumer seeks treatment from the chiropractor.

McDaniel's lawsuit accuses the defendants of telling accident victims that they will not receive any insurance proceeds from the accident unless they visit a specific chiropractor for treatment, among other actions in violation of the Arkansas Deceptive Trade Practices Act. The defendants have also implied that chiropractors would not charge for services, only for consumers to later discover that chiropractic clinics have filed medical liens.

Alzheimer's Arkansas to Turn 30

Alzheimer's Arkansas will be celebrating its 30th Anniversary on Tuesday, November 4th from 6-7:30 p.m. at its offices at 201 Markham Center Drive in Little Rock.

Light hors d'oeuvres and refreshments will be served and guests will hear from Brian Smith, Board President, and Sandra Day, a Family Assistance grant recipient, on the group's free programs and services for caregivers in Arkansas.

They will also commemorate the evening with a special tribute and memorial to loved ones with Alzheimer's with a "Night of Lights."

If you are interested in honoring a loved one with a light of your own, please call the office at 501-224-0021 or email them at www.alzark.org.

All of Alzheimer's Arkansas family and caregiver services are free of charge thanks to the generosity of friends in Arkansas.

UAMS Offers Auditory Graduate Certificate

The University of Arkansas for Medical Sciences (UAMS) College of Health Professions this fall will begin offering the first certificate program in the state for audiology and speech pathology graduate students seeking advanced skills to help children with hearing loss.

Faith Davies, MD

The Graduate Certificate in Auditory-Based Intervention will be offered by the college's Department of Audiology and Speech Pathology, jointly hosted by UAMS, the University of Arkansas at Little Rock, and Arkansas Children's Hospital.

Leading Clinician-Scientist Joins Myeloma Institute

The University of Arkansas for Medical Sciences (UAMS) has named internationally recognized clinician and researcher Faith Davies, MD, a professor of medicine and the director of the Phase I Clinical Trials Program for both the Myeloma Institute and the Winthrop P. Rockefeller Cancer Institute.

Davies will develop a program focused on innovative targeted molecular therapeutics. She is recognized internationally for her interest in novel therapeutics and her expertise in the treatment of relapsed refractory disease.

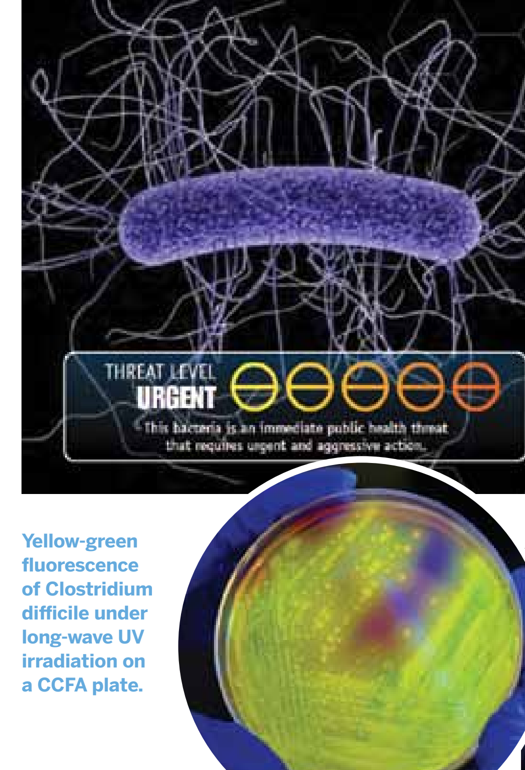
UAMS College of Nursing Grads Ahead of National Average

Recent graduates of the baccalaureate degree (BSN) program in the University of Arkansas for Medical Sciences (UAMS) College of Nursing recorded the highest pass rate of any Arkansas nursing college on the Registered Nurse (RN) National Council Licensure Examination (NCLEX). The 94.7 percent pass rate also exceeded the national average pass rate of 82.5 percent, according to data provided by the Arkansas State Board of Nursing. ■

Antibiotic Resistance is an Emerging Threat

One Which All Can Help to Fix

Antibiotics are powerful tools in the treatment of infections. However, after only 70 years of use their effectiveness is beginning to wane. Antibiotic resistance has been identified as a major public health threat by many organizations including the Centers for Disease Control and Prevention (CDC) and the World Health Organization. Successful efforts to slow resistance involve antimicrobial stewardship. Stewardship can be defined as the careful and responsible management of a limited resource. Experts agree that it will take a multidisciplinary, global effort to address this problem successfully.



Yellow-green fluorescence of Clostridium difficile under long-wave UV irradiation on a CCFA plate.

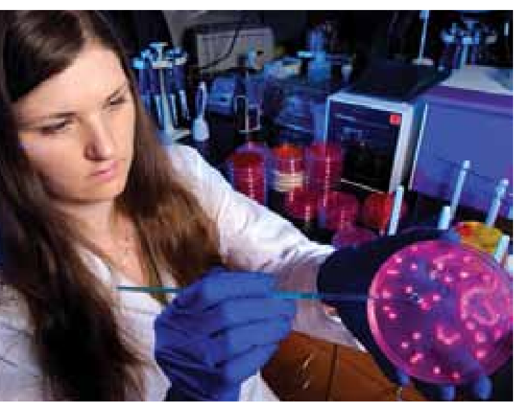
IMAGES COURTESY CENTERS FOR DISEASE CONTROL AND PREVENTION

How big of a problem is antibiotic resistance? The CDC estimates that in the US more than 2 million people a year are diagnosed with an infection that has some level of resistance and that 23,000 of those people will die as a result. Also concerning, are the development and spread of highly resistant bacteria sometimes called "superbugs". "Superbugs" can be so resistant to antibiotics that there may be no treatments available. Not surprisingly, this results in a higher mortality rate. In addition to antibiotic resistance, Clostridium difficile infections are also highly associated with antibiotic use. C. difficile infections routinely complicate a patient's recovery and extend hospitalizations and are thought to result in 14,000 deaths per year.

So what's the solution? Unfortunately, this is not an easy question to answer. Antibiotics are used for a variety of infections. Further, antibiotic resistant pathogens can be found not just in people, but in our pets, livestock, food, and the environment. There needs to be a balance in the use of these powerful infection fighting tools to avoid overuse and preserve the efficacy of antibiotics. The CDC outlined four key actions to address antibiotic resistance in their new report entitled "Antibiotic Resistance Threats in the United States, 2013" (http://www.cdc.gov/drugresistance/threat-report-2013/pdf/ar-threats-2013-508.pdf): prevent infections, track resistant bacteria, engage in antimicrobial stewardship to promote the best use of available antibiotics, and promote the development of new antibiotics and diagnostic tests for resistant bacteria. Each of these four strategies is vitally important to address this problem, but antimicrobial stewardship is the one action where everyone, including patients, can have an impact on reducing antimicrobial resistance.

One of the key concepts for antimicrobial stewardship is that antibiotics and similar drugs are a shared resource. The way antibiotics are used in one patient can have a direct influence on the effectiveness of that antibiotic in another patient. Antimicrobial stewardship focuses on appropriate prescribing practices by emphasizing that the right antibiotic be prescribed for the right diagnosis, the right amount of time, and at

Nathaniel Smith, MD, MPH
Director and State Health Officer,
Arkansas Department of Health



CDC microbiologist, Alicia Shams, demonstrates Klebsiella pneumoniae growing on a MacConkey agar plate. Klebsiella pneumoniae is the most common Enterobacteriaceae that is drug resistant.

the right dosage. While facilities vary, and so will their stewardship programs, CDC has outlined minimum standards for antibiotic stewardship programs:

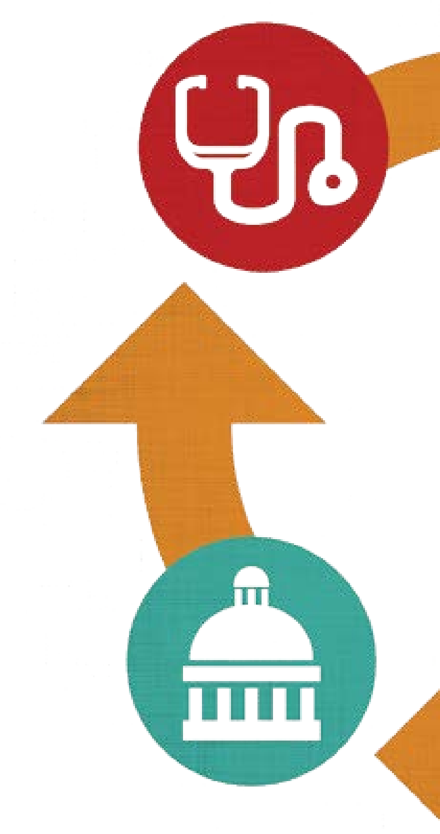
- Establish and maintain leadership commitment by dedicating necessary human, financial, and IT resources.
- Remain accountable by appointing a single leader responsible for program outcomes. Physicians have proven successful in this role.
- Provide drug expertise by appointing a single pharmacist leader to support improved prescribing.
- Take action to implement at least one prescribing improvement action; for example, requiring reassessment of drug choice, dose, and duration within 48 hours of starting an antibiotic.
- Monitor prescribing and antibiotic resistance patterns.
- Report prescribing and resistance patterns to staff, and implement steps to improve.
- Offer education about antibiotic resistance.
- Provide options to improve prescribing practices.

An effective antimicrobial stewardship program can benefit healthcare facilities in a number of ways. Some benefits include reducing infections, reducing costs, and reducing adverse drug events. Research has shown that by utilizing best practices for prescribing, one can reduce the number of resistant infections. Antimicrobial stewardship programs cultivate team-based problem solving by enhancing collaborations between the pharmacy, infection control, and laboratory departments to address a major public health threat and can be a model for addressing other such issues as they arise.

The Arkansas Department of Health (ADH) has a healthcare-associated infections (HAI) program that monitors antibiotic resistance associated with device usage, surgical site infections, methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infections, and C. difficile infections. Additionally, the HAI advisory committee (established by the Arkansas legislature in 2007) has made antimicrobial stewardship a priority and is partnering with other stakeholders to increase awareness. For example, the ADH partnered with the Arkansas Chapter of the American College of Clinical Pharmacy to host an antimicrobial stewardship summit in the fall of last year. This event was well attended by healthcare professionals from around the state eager to get more information on implementing successful antimicrobial stewardship in their own facilities.

The current focus of antimicrobial stewardship efforts is inpatient hospital programs, but to fully address resistance, efforts will be needed in outpatient health settings and in educating the public. Patients should be informed of the differences between bacterial and viral infections, the ineffectiveness of antibacterials for viral infections, the growing problem of antimicrobial resistance, the importance of taking the full course of antibiotic treatment, and that hand washing is the most important action to prevent infections. CDC's Get Smart campaign (www.cdc.gov/getsmart) has a wealth of information, resources, toolkits, and continuing education for those interested in a variety of healthcare settings.

To summarize, antimicrobial stewardship entails formalized strategies to ensure that antibiotics are used effectively. If we fail to act, infections that were once easily treated will become untreatable. Combating antimicrobial resistance is a winnable battle but it will take a unified effort from all to protect this endangered resource (antibiotics) for future generations of patients. ■



Arkansas's Health Care Workforce and Access to Care

Whenever there is an argument about our health care system, whether it is on Fox News or MSNBC, in the U.S. Congress or the Arkansas General Assembly, the issue is always the same. We want people to have easily accessible health care when we need (and when we want) it. We want high quality care for ourselves, our family, and our friends. We also want to be able to afford this care, whether we pay directly for premiums or indirectly through taxes for others. This is the "iron triangle"–access, cost, and quality. In almost every argument, someone is advancing the importance of one element over the other two.

Fox News: "Covering everyone under Obamacare is unsustainable and will break the federal budget." (Don't worry about access or quality). MSNBC: "Everyone deserves to benefit from the high quality of care offered by the U.S. health care system." (Don't worry about costs). Local news: "We can't afford to give access to everyone, if we insure everyone we won't have enough providers."

To accomplish real, sustainable improvement in our Arkansas health care system we have to find the solution to the puzzle of the "iron triangle" of health care–achieving necessary access, delivering high quality care, maintaining affordable health care costs.

To make the iron triangle work for us instead of against us we must ensure that we have the right health care workforce in place to meet the needs of our citizens within a transformed system. Providing more people with insurance coverage and improving the quality and efficiency of our existing health care workforce is not enough to ensure access to care when faced with a chronic shortage of health care providers in many parts of our state.

Addressing Arkansas's Health Care Workforce

Development of Arkansas's first strategic plan for addressing our health care workforce needs was undertaken in early 2011, culminating in the April 2012 release of the Arkansas Health Workforce Strategic Plan: A Roadmap to Change. The plan (available at achi.net) includes more than 50 recommendations, each assigned to a specific entity for development and related to these four overarching goals:

- Supporting the implementation of and transition to team-based care that is patient-centered, coordinated, evidence-based, and efficient.
- Enhancing and increasing the use of health information technology.
- Increasing the supply and improving the equitable distribution of primary care providers.
- Adoption of new financing, payment, and reimbursement policies and mechanisms.

The Arkansas Center for Health Improvement produced a second report, Arkansas Health Care Workforce: A Guide for Policy Action, that was released in March 2013. The report (also available at achi.net) provides a unique, multi-dimensional look at how and where health care is provided in Arkansas

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WWW.ACHI.NET

with findings that shed new light on a number of previous ideas and concerns. For example, much discussion has centered on the idea that we have a serious statewide shortage of health care providers. Information in the report quantifies our statewide shortage but highlights a far greater problem—maldistribution of providers. As a result of maldistribution, a person living in Pulaski, Craighead, Sebastian, or one of 14 other counties with larger metropolitan areas will find that there are enough or more than enough primary care physicians—pediatricians, family physicians, geriatricians, and internists—to meet demand. However, for people living in 61 of our 75 counties, the demand for primary care exceeds the supply of care providers. The shortage is most severe for people living in Newton, Calhoun, Lafayette, Cleveland, and Scott counties where the need by individuals for health care outpaces the available supply by 75 to 85 percent.

As of 2012, Arkansas had a supply of 2,077 primary care physicians (PCPs) and demand for services that suggests the need for 360 more. The state's supply of advanced practice nurses (APNs) and, to a lesser extent, physician assistants (PAs) blunts that shortage and is an important contribution to our workforce. However, the shortage nonetheless remains. Estimates show that increased health care coverage in Arkansas through the Health Care Independence Program and Health Insurance Marketplace will require an additional 60 primary care providers—either PCPs, APNs or PAs—to adequately meet demand. The state's chronic disease burden and aging population will continue to be the major driver of demand for primary services across the state.

Progress on Primary Care Workforce Supply

Actions taken in Arkansas to ameliorate the physician shortage include increasing enrollment in the University of Arkansas for Medical Sciences (UAMS) medical school from 150 to 174 with matriculating seniors in the class of 2009. Further, plans have now been approved to open two new private osteopathic medical schools, one in Jonesboro and the other in Fort Smith, though their impact on PCP supply is questionable at this point.

Efforts related to clinician education and training underway to correct the maldistribution of physicians and physician extenders include increasing funding to support non-physician clinician education for APNs and PAs. Currently, two new physician assistant programs have been implemented by the University of Arkansas for Medical Sciences (UAMS) and Harding University. UAMS will graduate its first class in 2015, and Harding admitted 36 students for the 2013 fall semester, which is an increase of almost 119% since 2005. In 2012, UAMS and Arkansas State University (ASU) approved their own Doctor of Nursing programs, as did the University of Arkansas (UA) in 2013 and the University of Central Arkansas (UCA) in 2014. This is in addition to the nurse practitioner programs currently offered at UAMS, ASU, and UCA.

The Federal Residency Cap and Physician Population Growth

The completion of a residency program, or graduate medical education (GME) program, at an accredited teaching hospital is the final step in becoming a practicing physician. Residency spots are primarily supported by federal funds flowing to accredited hospitals. Under the Affordable Care Act (ACA), initiatives are underway that serve to recruit and retain primary care clinicians in rural and underserved areas; however, the ACA provided only minimal increases to what is the biggest limiting factor to improving the health care workforce supply—the federal limit on funding for graduate medical education (GME) residency positions.

The cap on graduate medical education residency positions is a critical issue nationwide and severely impacts Arkansas's PCP supply. This is recognized in Arkansas's strategic plan which recommended that the number of GME residency slots in primary and preventive care, especially those dedicated to rural practice, be expanded. Because physicians are most likely to practice where they serve their residency, increasing the number of primary care residencies in rural areas is an effective way to increase physician supply in medically underserved areas.

UAMS has added 30 additional family medicine residency slots throughout the state with funding that became available through the Affordable Care Act. These positions are being phased in at a rate of six per year from 2011-2016. In addition, UAMS was recently the recipient of a $900,000 grant for support of six family medicine residencies at UAMS West in Fort Smith. While this represents some progress toward addressing supply issues, these additional primary care residencies will not be enough to address Arkansas's PCP demand.

Competition for Primary Care Residency

Osteopathic physicians (DOs) obtain training that is nearly identical to allopathic physicians (MDs). The primary difference is a greater focus on holistic, hands-on diagnosis and treatment along with a system of therapy known as osteopathic manipulative medicine. DOs–like their MD counterparts–are able to prescribe medications, diagnose and treat illnesses and injuries, and perform surgeries. In both cases, to be a physician, one must have an undergraduate degree, followed by four years of medical school, followed by a minimum of three years of training under supervision as a "resident." It is during residency that doctors have direct responsibility and learn to care for patients under the supervision of an experienced clinician.

Upon graduation, Allopathic (MD) and Osteopathic (DO) doctors compete for the same residency slots. Both the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine have spoken out recently about the crisis of limited federal GME programs.

Funding and plans are moving forward for opening two new private, for-profit osteopathic medical schools in Arkansas with an anticipated combined initial class size of 265 students. However, to date, no plans have been announced to provide funding for additional residency slots, or to locate these residencies in underserved areas where PCPs are most needed. While there is a potential for a greater influx of students to reduce the shortage of PCPs practicing in underserved areas of the state, it is unlikely to happen with reliance on an already strained publicly funded residency programs.

New medical schools without new residency programs were not part of the strategic plan. Increasing the number of medical school graduates without a lockstep increase in the number of residencies available will inevitably drive Arkansas medical school graduates out of state for their residency training, reducing the likelihood of these graduates practicing where we need them. As it stands, 18 UAMS seniors did not get a residency position during the 2014 residency match, which concluded in March.

Recently, an expert committee convened by the Institute of Medicine (IOM) released a report based on an evaluation of the current resident or graduate medical education (GME) program and recommendations for improving it. The evaluation report generated reactions highlighting the strengths but lamenting the gaps in our medical training programs. While it is too soon to tell what impact this will have on the residency program, I hope some future consideration will be given to policies that require for-profit medical schools to carry more of their own weight with regard to supporting their graduates' residencies. And, that this be done with consideration to reducing the issues of geographic and specialty maldistribution. The worst outcome will be for young, bright individuals to become indebted for hundreds of thousands in student loans, only to end up road-blocked by limited residency slots and fail to end up in one of the most satisfying professions caring for people.

MORE INFORMATION ON THESE INITIATIVES IS AVAILABLE AT ACHI.NET

While we are in a period of great transition for our health care system, recommendations in Arkansas's health workforce strategic plan highlight the most promising strategies to meet our challenges.

Conclusion

The Arkansas Health System Improvement Initiatives, now well underway across the state, are centered on the "iron triangle". Our goal is to improve the health of Arkansans by providing greater access to a health care system with higher quality patient care and contained cost. Inter-related initiatives have been designed to: improve our health care payment and delivery system; expand health insurance coverage; accelerate use of health information technology; and strategically plan for meeting our health care workforce needs.

The Arkansas Health Care Payment Improvement Initiative is accomplishing higher quality patient care and appropriate use of services contributing to affordable care. Its focus on team-based care with a physician leader of a team of advanced practice nurses and physician assistants supported by electronic health records and an encrypted communication platform is accelerating our progress. The Health Insurance Marketplace and Arkansas's own Health Care Independence Program, commonly known as the Private Option, are working together to remove financial barriers and improve access by providing health care coverage for many of the roughly one-half million Arkansans who were previously uninsured. (More information on these initiatives is available at the Arkansas Center for Health Improvement website, achi.net.)

Importantly, each of these initiatives supports our Arkansas health care workforce to create a more stable and fulfilling environment for clinicians. While we are in a period of great transition for our health care system, recommendations in Arkansas's health workforce strategic plan highlight the most promising strategies to meet our challenges.

When you find yourself in the next "health care discussion," remember the "iron triangle" – access, quality, and costs. Our system is changing and we need vocal supporters driving local, state, and federal policy to help find the solution. We are well on a path to solving the puzzle, lend your voice (Twitter @ARSurgeonGen, #ARHealth or Facebook, Arkansas Surgeon General). ■

Celebrating 30 Years of Caring

Please join us for a *Birthday Bash Celebration* celebrating our 30th Anniversary on Thursday, November 13th from 5-7 p.m. at our offices at 201 Markham Center Drive in Little Rock.

Hors d'oeuvres and refreshments will be served and you will hear from Brian Smith, our Board President, and Sandra Day, a Family Assistance grant recipient, on our free programs and services for caregivers in Arkansas.

We will also commemorate the evening with a special tribute and memorial to loved ones with Alzheimer's with a "Night of Lights."

If you are interested in honoring a loved one with a light of your own, please call our office at 501-224-0021 or email us at www.alzark.org.

All of our family and caregiver services are free of charge thanks to the generosity of friends in Arkansas. If you or someone you know is in need of our services, please call us or email us. You can reach our caregiver assistance line 24 hours a day, 7 days a week by calling 501-913-1878.

Why Join an ACO?

Better Quality, Shared Savings

Improving health care quality and reducing its costs – attributes of Accountable Care Organizations – have long been a part of the Arkansas Foundation for Medical Care's (AFMC) core values and goals. That's why AFMC plans to partner with Aledade, Arkansas' newest accountable care organization (ACO).

AFMC has worked hard to implement the patient centered medical home (PCMH) model with Arkansas providers. PCMH's emphasis on primary care is the future of health care in Arkansas and across the United States. PCMHs are the building blocks of an ACO.

America's current health care model of fee-for-service (FFS) is not sustainable. FFS creates powerful incentives to deliver more care and more tests, but not necessarily better care or the most cost-effective care. American health care is the most expensive in the world without correspondingly superior outcomes.

ACOs are evolving

The ACO concept is evolving but generally an ACO is a network of health care providers–including primary care physicians, specialists, and hospitals–that work together collaboratively and accept collective accountability for the overall care, cost, and quality that is delivered to a defined patient population. When providers generate savings, there is a promise of sharing those savings.

ACOs are accountable for cost and quality within and outside of the primary care relationship, including specialists and hospitals. Comprehensive care is necessary to control costs and improve health outcomes across the entire care continuum.

ACOs were given an initial boost by the Affordable Care Act (ACA). The ACA permitted Medicare to reward health care organizations with a share of the savings that resulted from improved quality and lower costs for Medicare beneficiaries' care.

Medicare was an early adopter of ACO concepts because, with the transition of 70 million-plus baby boomers to Medicare, the program was not financially sustainable. The ACO model is being watched closely by Medicare for financial results.

Currently, 5.3 million Medicare beneficiaries are enrolled in ACOs under the Medicare Shared Savings Program (MSSP). Additionally, more than 30 million Americans now receive health care through an ACO.

PCMHs operate effectively with the ACO model because ACOs can manage multiple PCMHs. The economies of scale with larger patient populations facilitate overall cost management, less variation within the population, and the ability to track and trend for quality.

Variations on a theme

ACOs are generally either physician-led or hospital-led. They can be formed around a variety of health care provider organizations such as multi-specialty medical groups, physician-hospital organizations (PHO) or independent practice associations. They must be able to manage both cost and quality for a defined patient population.

Many of the more than 600 already established ACOs are run by private insurance companies that have the ability to track patient data and evaluate care costs. Analytical ability is crucial to a successful ACO. However, unless insurance companies develop networks of providers and use actuarial data to provide efficient and effective care, they could be bypassed by ACOs.

AFMC has been a respected, long-time leader in the key areas of ACO success. AFMC brings an in-depth knowledge of Arkansas' health care environment to the ACO initiative. We have both earned the trust of and have a good working relationship with the state's physicians and other key stakeholders. AFMC also has an experienced and trusted analytical capacity. Our veteran work force understands the unique needs of both providers and Arkansas consumers.

While some HMOs can meet the requirements of an ACO, most HMOs still rely on payment contracts with a network of mostly disaggregated physicians and hospitals, or they have developed into fully integrated delivery systems but only serve the HMO's insured patients. Kaiser Permanente is a highly successful example of the latter.

How ACOs would change your practice

Health care payments are shifting from a volume-based system to a system based on value and quality. With this shift, primary care physicians (PCPs) will increasingly feel pressure to make changes in how they practice medicine.

AFMC believes it is critical to strengthen independent PCPs in a rural state like Arkansas.

Ray Hanley
President and CEO,
Arkansas Foundation
for Medical Care

"Physician-led ACOs are appealing to PCPs because they give the PCP control over patients' health care through the power of information and the totality of care coordination."

Physician-led ACOs are appealing to PCPs because they give the PCP control over patients' health care through the power of information and the totality of care coordination. Better control means improved quality and lower costs.

A PCP practicing in an ACO will continue to receive payment for his or her services. By practicing in a more efficient manner through care coordination, chronic disease management, and focusing on disease prevention, PCPs can capture the value they create for the health care system.

Joining an ACO is voluntary. A PCP's hesitancy to join an ACO can stem from concerns about the uncertainty of making fundamental changes in his or her business model. ACOs require a culture of self-reflection and assessment, continuous improvement, flexibility, and information sharing and analysis. ACOs support and reward continuous quality improvement.

PCPs must also believe the shared savings are going to be there. And while an independent PCP can probably survive on their own, an ACO gives him or her the opportunity to thrive and improve quality. An ACO can provide valuable tools such as IT expertise and "boots on the ground" to help transform the practice, and training to facilitate quality improvements. An ACO can also help PCPs navigate the considerable business applications, and the legal ramifications that permit collaboration and integration.

Are the savings real?

Claims data demonstrate that ACOs' shared savings are real. The Congressional Budget Office has projected that ACOs will save $5.3 billion nationwide from 2010-2019.

ACOs reduce costs by improving care coordination, avoiding unnecessary hospitalizations and emergency department visits, improving chronic disease management, avoiding unnecessary tests and procedures, and increasing focus on disease prevention. Potential savings will depend on how effective ACOs are in improving quality, containing costs, and whether the ACOs can handle the different expectations of multiple payers.

Many proponents say the real savings will come from quality improvements.

Attracting patients

Improving a patient's engagement in health care is another benefit of ACOs. While Medicare automatically enrolls patients in ACOs, non-Medicare patients can be encouraged to participate in an ACO when they understand the numerous benefits of receiving "the right care at the right time and in the right setting." An ACO care team will more effectively communicate and encourage better-informed consumer decisions, which will result in higher quality care.

The patient becomes the focus of care. Patients will spend less time filling out medical history forms because the information is available electronically (EHR). Patients may have access to a patient portal, enabling the provider to securely share information about their visit with patients, including lab results. This increased efficiency creates a leaner workflow in the practice and provides quicker patient access to test results. Patients will see fewer medical tests and co-pays, less stress, and fewer doctor visits.

Patients can choose their own providers and are not required to stay in the ACO network for any or all of their health care. This is not an option with HMOs or HMNs.

ACOs improve managed care

Managed care has been around a long time. ACOs can provide better care than HMOs because ACOs must meet an extensive list of quality standards.

HMOs are typically criticized for giving control of a patient's health care to the insurance company, not his or her physician. ACOs put the control back in the hands of PCPs.

The founder of Aledade, Farzad Mostashari, MD, says that "longitudinal patient care" means accountability to all patients and knowing everything health-care-related that's happening to your patients: are they being hospitalized, taking their meds or bouncing from specialist to specialist?

"Unless you have this data on each patient, you cannot control their health care and thus make it more effective, higher quality, and save costs in the process," Mostashari told the *Health Care Blog* in March.

"I was trained in an era where we were not supposed to think about, or even be aware of, the cost implications of our care recommendations. I now believe that we need physician engagement in addressing the truly unsustainable rise in healthcare costs that threaten to bankrupt our nation," he says.

If you have questions about the ACO model, contact Nathan Ray, MBA Director, HIT Arkansas, at nray@afmc.org or 501-212-8616. ■

A Call to Action for Nursing

Perhaps no other publication in recent memory has energized the nursing profession as has the 2010 report and 2011 publication from the Institute of Medicine (IOM), The Future of Nursing: Leading Change, Advancing Health. The Robert Wood Johnson Foundation (RWJF) and the IOM recognized that changes in the U. S. healthcare system to improve care, quality, and cost should include the participation and transformation of the nation's largest healthcare workforce – nurses. After a two year study and evaluation of the evidence, the committee, chaired by Dr. Donna Shalala, defined the following key messages for fundamental change:

Practice Nurses should practice to the full extent of their education and training. This includes removing barriers that unnecessarily delay care for patients. The barriers that exist for advanced practice nurses are well known and well described in the body of the IOM report. One such example is the inability of APRNs to sign for home health plans of care for their Medicare patients. Other issues include primary care provider status for Medicaid patients and designation as leaders of Patient Centered Medical Homes.

Education Nurses should achieve higher levels of education and training within systems which promote seamless academic transitions. The goal is to increase the number of baccalaureate prepared nurses to at least 80% by 2020 and doctorally-prepared nurses to at least 20% by 2020. As of 2013, 29% of RNs in Arkansas had obtained a baccalaureate degree (Arkansas State Board of Nursing, 2013). Nationally, only 1% of nurses have a doctoral degree in nursing; 13% of nurses have graduate degrees. Since nurses with graduate degrees are involved in leadership, research, practice, and education, the need for more seems obvious. In Arkansas, 2.3% of advanced practice nurses have doctoral degrees and only 0.5% of all RNs (including APRNs) have doctoral degrees (Arkansas State Board of Nursing, 2013).

Leadership Nurses should be full partners with medicine and other stakeholders in the redesign of healthcare in the U.S. This includes membership on healthcare panels and boards developing policy as well as leading and working collaboratively with interprofessional groups. Many may not realize that the IOM report features the Arkansas Aging Initiative with Drs. Claudia Beverly and Amyleigh Overton-McCoy in describing one patient's experience with a nurse practitioner within an interprofessional team.

Workforce Planning Nurses should advocate for better workforce planning through improved data collection and information infrastructure. The need for better data collection and analysis is reflected in the creation of the National Health Workforce Commission and the National Center for Workforce Analysis (Institute of Medicine, 2011). Many of the nursing services are invisible to data collection. "Incident to" billing obscures the care delivered by non-physician providers such as APRNs and Physician Assistants. Even more obscure is the RN contribution to quality outcomes. Databases such as the NDNQI capture nurse sensitive indicators in the acute care setting of participating facilities (National Database of Nursing Quality Indicators, 2012). In the ambulatory setting, data collection is even more difficult. When trying to measure care coordination activities, the American Nurses Association's Congress on Nursing Practice and Economics health policy group found relatively few studies which specifically measured nursing activities, including APRN activities (American Nurses Association, 2012a, 2012b; Antonelli,

Rhonda Finnie
DNP, APRN, AGACNP-BC, RNFA
President, Arkansas Nurses Association

Stille, & Antonelli, 2008; Naylor, Aiken, Kurtzman, & Olds, 2010; Rantz et al., 2011).

The 700 page IOM report called for action from not only the nursing profession, but also from stakeholders in the larger healthcare community. As a result, the Campaign for Action, a joint initiative between the Robert Wood Johnson Foundation and AARP, was created and Action Coalitions began to form across the country to address these issues, promoting specific strategies to accomplish this transformation.

Working within the silos of education, practice, and public policy is not effective. The Coalitions have brought administrators, educators, clinicians, and public stakeholders to the same table to address challenges and promote opportunities to implement a future for nursing consistent with evidence-based patient centered care. Arkansas' 52,000 nurses and the patients and families they serve will benefit from the implementation of the report.

ARKANSAS' 52,000 NURSES AND THE PATIENTS AND FAMILIES THEY SERVE WILL BENEFIT FROM THE IMPLEMENTATION OF THE REPORT

The Arkansas Action Coalition's leadership team includes Claudia Beverly, Lorraine Frazier, Cheryl Schmidt, Herb Sanderson, Sandie Lubin, Erin Fifer, Debra Jeffs, Rebecca Burris, Angela Green, Susan Patton, Linda Castaldi, Patricia Scott, Mary Garnica, Amy Huett, and Kerry Jordan. As a result of their efforts, in December, 2013, Arkansas was one of 10 states which received a two-year grant from the RWJF to support this work. This coalition continues its mission focused on the four pillars above. They exemplify the quote from Goethe located inside the front cover of the report, "Knowing is not enough; we must apply. Willing is not enough; we must do." ■

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HOSPITAL Rounds

HOSPITAL NEWS & INFORMATION

BAPTIST HEALTH BREAKS GROUND IN CONWAY

Baptist Health held a ground-breaking ceremony on a 37-acre site in Conway to mark the start of construction on the new Baptist Health Medical Center-Conway. SEE PAGE 60 FOR DETAILS

HOSPITALROUNDS

Donation Funds New Neurosurgical Robot

Through a donation of $402,000 by the late Edwin "Brad" Bradberry, the University of Arkansas for Medical Sciences (UAMS) Medical Center recently purchased a neurosurgical robot, ROSA, to be used in stereotactic procedures for epilepsy and oncology.

Use of the device makes procedures less invasive, significantly shorter, and much safer by improving surgical accuracy, while minimizing the risks of pain or infection.

UAMS is one of only five medical centers in the United States to have a ROSA (Robotized Stereotactic Assistant). Stereotactic surgery uses a three-dimensional coordinate system to locate small targets in the body for minimally invasive surgery

Neurosurgeon and epilepsy specialist Demitre Serletis, MD, PhD, leads the Epilepsy Surgery Program in the UAMS Department of Neurosurgery and is an assistant professor in the UAMS College of Medicine.

"By integrating cutting-edge robotic technology such as the ROSA device into the university's comprehensive Epilepsy Surgery Program, the Bradberrys' contribution goes a long way toward developing an even greater standard of exceptional patient care and research at our center, the newly established Edwin and Karlee Bradberry Center for Robotic Neurosurgery," said Serletis.

A Crossett native and Fayetteville resident, Brad Bradberry had a decades-long career in the petroleum industry. He also served as vice chair of the UAMS Foundation Fund Board, a member of the Advisory Board of the UAMS Harvey & Bernice Jones Eye Institute, and a member of the Advisory Board of the University of Arkansas, Fayetteville. He donated the funds for the ROSA just a few months before he passed away June 16.

ROSA has a robotic arm that features high dexterity for surgically precise movements, and also employs a noninvasive laser for accurate measurements that together provide a type of "GPS for the brain," according to Montpellier, France-based Medtech, which designed and manufactured the technology. It gives the neurosurgeon the ability to guide the instruments manually and easily within limits and restrictions established during the planning phase. The ROSA also offers an upgradable technology that allows for continual improvement and other neurosurgical applications.

ACH Heart Care Among Best

Families in Arkansas receive world-class care for their children's heart conditions, according to *U.S. News and World Report*, which ranked Arkansas Children's Hospital (ACH) among its Best Children's Hospitals 2014-2015 list for Cardiology and Heart Surgery. The annual list ranked ACH's heart transplant program as "superior" and also gave high marks to its nurse:patient ratio and pressure ulcer prevention strategies. The program ranked No. 35 on the pediatric subspecialty list for Cardiology and Heart Surgery.

Arkansas Children's Hospital offers the only pediatric heart transplant program in the state, and treats patients from throughout the region for complex conditions that can't be addressed elsewhere. In 2011, ACH set a national record for pediatric heart transplants, saving the lives of 31 children through the gift of donor organs. The unit offers 37 beds for children with congenital heart defects and also treats adults who were diagnosed with heart conditions during childhood.

Five-sixths (83.3 percent) of each hospital's score relied on patient outcomes and the care-related resources each hospital makes available. To gather clinical data, *U.S. News* sent a clinical questionnaire to 183 pediatric hospitals. The remaining one-sixth (16.7 percent) derived from three years' of responses to an annual survey of 150 pediatric specialists and subspecialists in each specialty. The physicians were asked where they would send the sickest children in their specialty, setting aside location and expense.

System Integration Means Loss of Some Positions

The change of membership of the Hot Springs health ministry on April 1, 2014 to CHI St. Vincent created a new, Catholic, integrated system of hospitals, physician clinics, outpatient services, and an accountable care organization (the Arkansas Health Network) in central and southwest Arkansas. To accelerate the integration process, the Board and leadership of CHI St. Vincent embarked on a journey to transform every aspect of the ministry from how the boards operate to how leadership is structured to how the system improves the quality, experience, and safety of patient care.

As part of the integration process, an intense review of all CHI St. Vincent ministries has been underway to address bringing together two historically separate organizations by consolidating several key corporate functions, maintaining a lean leadership structure, and ensuring consistent and equitable operations across the health system. As a result of this review, CHI St. Vincent announced it would be reducing 157 positions in a total workforce of more than 4,500. From the positions impacted, there will be no more than 91 impacted individuals at CHI St. Vincent.

During the process, St. Vincent sought to minimize the impact on direct patient care and every attempt was made to also minimize the actual number of impacted workers by evaluating job openings, utilizing normal turnover, and shifting workers to different areas.

Impacted workers at CHI St. Vincent Hot Springs will follow Mercy's severance policy per its agreement with Mercy in the transfer of membership to CHI St. Vincent. Impacted workers at all other locations will follow CHI St. Vincent's standard severance policy.

UAMS Neighborhood Clinic Opens in West Little Rock

Continuing its commitment to expand primary care and specialty services to meet the needs of its patients, the University of Arkansas for Medical Sciences (UAMS) opened a UAMS Neighborhood Clinic in west Little Rock this summer.

The clinic, located at 1811 Rahling Road, is open 7:30 a.m.-5 p.m. Monday through Friday, with extended hours until 8 p.m. Tuesdays and Thursdays for patient convenience. It offers primary care to all members of a family, from pediatric to geriatric patients. Specialty care, including cardiology, urology, neurology, gastroenterology, and endocrinology, is also offered.

The clinic has a full-time staff of 25, including

Chuck Smith, MD

three physicians. Services range from annual exams and preventive care to specialists who can help manage complex conditions and illnesses.

Chuck Smith, MD, is the medical director of the clinic. He is an assistant professor in the College of Medicine's Department of Family & Preventive Medicine and a primary care doctor.

NPMC Announces 2014 Junior Volunteers

National Park Medical Center welcomed a record 28 junior volunteers to their facility for the annual Junior Volunteer Summer Service Program. The program is designed to help area students learn more about the healthcare industry and to give them real-life workplace experience.

This year's junior volunteers were Brandon Knobloch, Kevin Kowalkowski, Kaitlyn Blackstone, Paige Whitley, Shelia Galloway, Ashleigh Andres, Megan Briggs, Abby Bailey, Lauren Goodwin, Brittany Dooley & Hannah Gamberini. Back Row: Whitney Caldwell, Nickiyah Hudson, Clayton Threadgill, Colton King, Dakota Jones, Evan Morgan, Haleigh Dooley, Amy Singleton, Dylan Mitchell, Stacey Brown, Sydney Lee, Jessa Goodeaux and Carissa Crumpton, Emily Dunn, Riddhi Modi, and Cameron Pate.

The volunteers worked in various hospital departments, both medical and non-medical in nature. Tasks included support services for both patients and employees. Each teen received training in patient privacy practices, HIPAA regulations, phone & customer service etiquette, wheelchair safety, hospital codes, fire and safety, and infection control.

The program accepts students between the ages of 14 and 17, and begins accepting applications in March of each year.

EZ Spanish Media Raises Funds for ACH

EZ Spanish Media, parent company of La Zeta radio stations in Little Rock and Northwest Arkansas, recently raised $317,000 for the patients and families at Arkansas Children's Hospital.

Two Creadores de Milagros (Miracle Makers) Radiothons aimed at bilingual Hispanic listeners were hosted, one in Little Rock and one in Northwest Arkansas. The second annual La Zeta 106.3 Radiothon, held in Little Rock, raised $91,595. The fifth annual La Zeta 95.7 Radiothon, held in NWA, raised $226,050. The total amount raised for Arkansas Children's Hospital by EZ Spanish Media over the last five years is $1 million.

During the Radiothons, patients and caregivers were interviewed throughout each day, putting into words the stories of care, love, and hope that happen daily at ACH. Listeners were encouraged to call and make a donation to the hospital or become a 'Miracle Maker' through ongoing monthly contributions.

This gift from EZ Spanish Media and the Hispanic community is being celebrated as part of the ACH Century of Possibility Campaign. All funds raised during the campaign will support pediatric care, research, education and prevention programs all over the state. Currently, ACH has raised $149 million of its $160 million goal. The Century of Possibility campaign will conclude December 31, 2014.

Arkansas Children's Hospital Receives National Awards

Arkansas Children's Hospital (ACH) recently received 13 National Excellence in Healthcare Awards from Professional Research Consultants (PRC) for achievement and quality of care.

Several areas throughout the hospital received 2014 Patient Perception Awards for overall quality of care. Areas receiving 5-Star designation with patient satisfaction ratings in the top 10 percent (at or above the 90th percentile) include the Pediatric Intensive Care Unit (PICU), Cardiac Intensive Care Unit (CVICU), Burn Center, Surgery department, Neonatal Intensive Care Unit (NICU), Hematology/Oncology services, ENT Clinic, and the ACH Laboratory. The ACH Outpatient Surgery department also received Top Performer status with patient satisfaction ratings at or above the 100th percentile.

Matthew Pearson, process improvement

Baptist Health Breaks Ground In Conway

coordinator at ACH, and the ACH Outpatient Surgery departments both received Platinum Achievement Awards for quality initiatives developed and implemented at ACH. Achievement Awards recognize organizations at the hospital, facility, department or unit level that have enhanced their patients› experience by focusing on their Key Drivers of Excellence®.

The 2014 PRC National Excellence in Healthcare Awards were presented at the Excellence in Healthcare Conference in St. Louis, Missouri.

Baptist Health Breaks Ground In Conway

Baptist Health held a ground-breaking ceremony on a 37-acre site in Conway to mark the start of construction on the new Baptist Health Medical Center-Conway. Baptist Health president and CEO Troy Wells, Gov. Mike Beebe, civic leaders, community members, local physicians, and Baptist Health employees celebrated the official start of construction for the 96-bed hospital that will be located on the west side of Interstate 40 in Conway.

The 216,000-square-foot Baptist Health Medical Center-Conway is projected to open in the first quarter of 2016 with 96 beds, eight operating rooms, and a Level III trauma-center emergency room.

Baptist Health collaborated on this project with more than 30 Conway-based physicians to develop the new medical center. It will be operated as a not-for-profit, faith-based community hospital offering comprehensive clinical services.

The construction project is expected to generate approximately 250 jobs. At the time of completion, Baptist Health Medical Center-Conway will employ around 425 healthcare professionals and staff committed to improving the health of the community.

The estimated cost of the entire project is $130 million.

Barnes Named Chair of UAMS Orthopaedic Surgery

C. Lowry Barnes, MD has been named chair of the Department of Orthopaedic Surgery at the University of Arkansas for Medical Sciences (UAMS). He will hold the Carl L. Nelson, MD, Chair in Orthopaedic Surgery.

Barnes, a joint replacement expert, has been a UAMS professor of orthopaedics for the past three years while he continued his private practice. He will see patients at UAMS and continue seeing patients in his practice at Arkansas Specialty Orthopaedics and St. Vincent Infirmary Medical Center.

In his new role, Barnes will lead an important transformation in how orthopaedics is practiced at UAMS and in Arkansas, said G. Richard Smith, dean of the UAMS College of Medicine.

Barnes graduated with honors from the UAMS College of Medicine in 1986. He stayed at UAMS for his internship and residency in orthopaedic surgery. Barnes completed a fellowship in Adult Reconstructive Surgery and Arthritis Surgery at Harvard Medical School and Brigham and Women's Hospital in Boston.

In 1998, Barnes was founding managing partner of Arkansas Specialty Orthopaedics, where he was president for more than a decade. He has long been active at St. Vincent Infirmary Medical Center, serving on the board of directors from 1997-2010 and as president of the St. Vincent Infirmary Physician Hospital Organization.

Barnes holds four patents for orthopaedic surgery devices that he developed and has designed numerous hip and knee implants. Barnes is also known nationally for his expertise in health care quality, efficiency and new payment structures that were ushered in with health system reform.

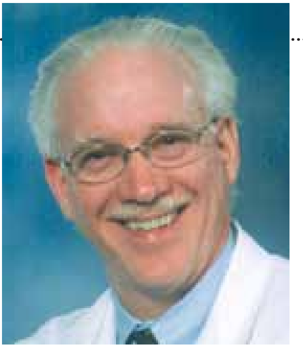
New CHI St. Vincent Family Clinic in Bryant

B. Gennice Perry, MD is now seeing patients at the new CHI St. Vincent Family Clinic Bryant. Perry completed her doctorate of medicine in 2000 and a Master of Science Degree in Occupational and Environmental Health in 1996 at the University of Arkansas for Medical Sciences.

In addition CHI St. Vincent Heart Clinic Arkansas cardiologists are now seeing patients at CHI St. Vincent Family Clinic Bryant. Charles W. Clogston, MD, Forrest D. Glover, MD, and Aravind Nemarkommula, MD will conduct cardiology clinics each

C. Lowry Barnes, MD

B. Gennice Perry, MD


Charles W. Smith, MD

Castro Bali, MD

Tuesday, Wednesday, and Thursday of the month. The three cardiologists have discontinued clinics at the Benton location at 5 Medical Park Building B Suite 205.

CHI St. Vincent Family Clinic Bryant is located at 21357 I-30 Frontage Road Suite 101 in Bryant.

UAMS Chooses Smith to Lead New Service Line

Longtime educator and physician Charles W. Smith, MD, has been named director of the Primary Care Service Line for the University of Arkansas for Medical Sciences (UAMS).

Smith will transition out of his current role as executive associate dean in the UAMS College of Medicine, to oversee planning, development, and implementation of the service line, which includes working with the chairs of the various primary care-oriented departments.

"With the opening of our new neighborhood clinics at Financial Centre Parkway and Rahling Road, we are accelerating the startup of the Primary Care Service Line to adequately support these clinics," said Roxane Townsend, MD, vice chancellor for clinical programs and CEO of UAMS Medical Center.

A service line is a grouping of all products and services within a division to improve coordination of services for the patient. Eventually, all primary care services sponsored and supported by UAMS will be a part of the service line.

"As founder of the UAMS Center for Primary Care, Dr. Smith has been focusing increasingly on this vital component of our clinical enterprise in the past few years. He is ideally suited for this new role," said Townsend, also citing Smith's 25 years in promoting clinical programs and clinical teaching in the College of Medicine.

Smith has long had an interest in and been an advocate for electronic medical record (EMR) implementation and facilitating the use of web technology. He chaired the implementation committee for the campus' first EMR system and has remained an active leader in EMR adoption, including the comprehensive new EPIC system.

Smith has also been a leader in the development of online physician consultation and a patient portal that allows patients to access lab tests and pay their bill online. In 1997, in the early years of widespread public adoption of the Internet, he founded an award-winning, Web-based medical information company, eDocAmerica, a UAMS BioVentures-supported startup that provides patients with tools, information and input from medical professionals to help individuals make better decisions about their health and health care.

Prior to his recruitment to UAMS, Smith was dean of the School of Primary Medical Care at the University of Alabama School of Medicine in Huntsville. He received his medical degree from the University of North Carolina in Chapel Hill, where he completed his family practice residency.

Bali Joins Diabetes & Endocrinology Clinic

Castro Bali, MD is now accepting new patients at CHI St. Vincent Diabetes & Endocrinology Clinic. Dr. Bali is board certified in internal medicine and is board eligible for endocrinology.

Dr. Bali completed his internal medicine residency at the University at Buffalo, State University of New York and earned a fellowship in endocrinology, diabetes, and metabolism at the University of Arkansas for Medical Sciences.

Rock the Runway Benefits Cancer Patients at UAMS

Little Rock got a taste of New York Fashion Week at the second annual Rock the Runway event. In front of about 500 guests, the runway show featured the latest fashions from 16 central Arkansas boutiques. Several local cancer survivors were featured models in the show, which benefited the Winthrop P. Rockefeller Cancer Institute at the University of Arkansas for Medical Sciences (UAMS) and Fighting Fancy, a nonprofit organization that supports women with cancer.

The event's proceeds, which totaled about $80,000, will be split between the two organizations to fund cancer patient support services.

ACH Launches Versant RN Residency Program

Arkansas Children›s Hospital (ACH) has partnered with Versant RN Residency to offer an 18-week nursing residency program to ACH new graduate Registered Nurses. This formalized residency program will benefit its participants, the hospital, and the patients, especially in the hospital's ongoing commitment toward quality and safety grounded in evidence-based practice.

As CNO and Senior Vice President, Lee Anne Eddy, noted, "Versant has demonstrated a program that significantly enhances the new graduate RN transition to professional practice, prepares a confident beginning level staff nurse who provides competent and safe patient care, and increases new graduate RN commitment and retention within the organization."

The Versant RN Residency program at ACH offers:

A comprehensive education and training

system, developed using Patricia Benner's Novice to Expert framework, and designed to transition newly graduate registered nurses from students to safe, competent, and professional practitioners at ACH (www.versant.org)

A competitive program required for all ACH new graduate hires, with 60 RN-I openings per year

An 18-week immersion program composed of approximately 80% clinical time and 20% classroom time

For more information, visit www.versant.org

Saline Memorial Earns Patient Safety Excellence Award™

Saline Memorial Hospital announced that it has achieved the Healthgrades 2014 Patient Safety Excellence Award for two years in a row (2013-2014). The distinction places Saline Memorial Hospital (SMH) within the top 5% of all hospitals for its excellent performance in safeguarding patients from serious, potentially preventable complications during their hospital stays according to Healthgrades, the leading online resource for comprehensive information about physicians and hospitals.

When compared to hospitals performing in the bottom 5% for patient safety, patients treated in Healthgrades 2014 Patient Safety Excellence Award recipient hospitals, on average, were:

- 73% less likely to experience pressure sores or bed sores acquired in the hospital compared to hospitals ranked in the bottom 5% in the nation.
- 72% less likely to experience a hip fracture following surgery compared to hospitals ranked in the bottom 5% in the nation.
- 67% less likely to experience catheter-related bloodstream infections acquired at the hospital compared to hospitals ranked in the bottom 5% in the nation. *

Over the past few years, SMH has implemented a number of patient safety initiatives including:

- In 2011, SMH implemented a Patient/Family activated Rapid Response Team. If a family or patient feels something isn't quite right about their health, they can activate the Rapid Response Team (ICU Nurse, Respiratory Therapist and Physician), this team immediately responds to the bedside to assess the situation.
- The SMH leadership team rounds on all new patients daily. This helps to identify patient safety issues and or concerns in real-time. Nurse Managers and clinical coordinators also visit patients preoperatively to identify safety concerns or other issues prior to surgery.
- All shift change reports are done in the patient's room for continuity of care and to involve the patient and their family. This provides an opportunity for patients to be involved in their plan of care and address any safety concerns before the next nurse takes over.

**Statistics are based on Healthgrades application of QI Windows® Software (version 4.4), developed by the Agency for Healthcare Research and Quality (AHRQ), to MedPAR data for years 2010 through 2012 and represent 3-year estimates for Medicare patients only.*

Baptist Little Rock Campus Renamed For Harrington

In honor of Baptist Health's former CEO and President Russ Harrington's retirement after 40 years of service to Baptist Health, the Board of Directors renamed the Little Rock hospital campus the Russell D. Harrington, Jr. Campus.

New signage located at the front entrance of the campus as you enter and exit the interstate was unveiled recently. More than 325 employees, friends, and family made a monetary donation to Baptist Health Foundation and a keepsake book with their names was presented to Harrington at System Update on the same day as the unveiling.

Troy Wells was named by the organization's board of trustees as the new president and CEO upon Harrington's retirement on July 1. Baptist Health's board of trustees also announced other promotions to Baptist Health's executive team following Harrington's retirement. Doug Weeks is now executive vice-president and chief operating officer, and Bob Roberts is executive vice-president and chief financial officer.

Harrington will continue to serve the organization in the role of president emeritus and senior advisor.

Nallur Joins CHI St. Vincent Family Clinic

Shiva Nallur, MD is now seeing patients at the CHI St. Vincent Family Clinic Rodney Parham. Nallur completed his residency in family medicine at the University of Arkansas for Medical Sciences. He is a board certified family physician, a member of the American Board of Family Medicine and the national and Arkansas chapters of the American Academy of Family Physicians.

CHI St. Vincent Family Clinic Rodney Parham is located at 10000 N Rodney Parham Rd. in Little Rock.

UAMS Neurosurgeon First in Arkansas to Implant New Spinal Cord Stimulation Device

The University of Arkansas for Medical Sciences' (UAMS) Erika Petersen, MD, recently became the first neurosurgeon in Arkansas to implant in a

patient the Protégé IPG device, the world's first and only neurostimulation system that can be updated through software rather than surgery.

Until now, one of the greatest challenges with spinal cord stimulation therapies has been giving patients access to the latest technologies without surgically replacing their medical device. The new technology can access innovative therapies, stimulation modes, diagnostics or other features, as they receive Food and Drug Administration approval through future software upgrades — without the need to surgically replace their medical device.

Protégé IPG is made by St. Paul, Minnesota-based St. Jude Medical, a medical device company. The FDA in April approved its use in patients.

Similar in function and appearance to a cardiac pacemaker, the Protégé neurostimulator delivers mild electrical pulses to the spinal cord, which interrupt or mask the pain signals' transmission to the brain. By masking the pain signals, patients who receive neurostimulation may see an overall improved quality of life.

Casimire Joins CHI St. Vincent Hot Springs

Thalia Casimire, MD, has joined the CHI St. Vincent Pulmonology Clinic in Hot Springs. Casimire is fellowship trained in pulmonary, critical care, and sleep medicine. She will work alongside Idrees Mogri, MD; Nizar Suleman, MD; and Youssef Yammine, MD.

Casimire completed her Bachelor of Medicine from the University of the West Indies, Faculty of Medical Sciences. She completed her Internal Medicine residency and Pulmonary/Critical Care Medicine fellowship at the State University of New York-Downstate Medical Center and her Sleep Medicine fellowship at the New York University School of Medicine.

CHI St. Vincent Pulmonology Clinic is located at One Mercy Lane, Suite 401 in Hot Springs.

Shiva Nallur, MD

Thalia Casimire, MD

Baptist Implements Telehealth for Breastfeeding Moms

Baptist Health has implemented a telehealth lactation-consulting program with the help of a grant from the Blue & You Foundation for a Healthier Arkansas. Nurses at Baptist Health Medical Center-Arkadelphia can now take an iPad to the bedside of a new mother and consult with another nurse who is a certified lactation consultant on staff at Baptist Health Expressly For You.

Breastfeeding rates in Arkansas are among the lowest in the country. In "The CDC Guide to Strategies to Support Mothers and Babies," access to professional breastfeeding support is a key strategy. International board-certified lactation consultants are healthcare professionals who specialize in the management of breastfeeding and are identified in the Centers for Disease Control & Prevention guide as effective in improving hospital maternity-care practices and breastfeeding rates.

Baptist Health Expressly for You has a breastfeeding warmline that serves as a telephone support line for breastfeeding mothers all over the state. The new telehealth lactation-consulting program is an improvement to the warmline by allowing women who deliver a baby in a hospital without a lactation consultant to be able to access one. Plans are under way to extend this program to more hospitals by the end of this year.

Erika Petersen, M.D., shows Steve Moore, a patient who uses the Protege spinal neurostimulator, one of the parts of the device's system.

Adams Named Director of Children's Nutrition Center

The Arkansas Children's Nutrition Center (ACNC) on the campus of Arkansas Children's Hospital (ACH) will be under new leadership for the first time since its 1995 inception when a scientist renowned for his research in human nutrition takes the helm later this year.

Sean Adams, PhD, is research leader for the Obesity and Metabolism Research Unit of the USDA's Western Human Nutrition Research Center, and an associate professor in the Department of Nutrition at the University of California, Davis. He has two decades of experience investigating metabolic physiology and the causes and consequences of obesity and metabolic disorders.

Dr. Adams will become the center director and appointed professor and chief of the Division of Developmental Nutrition in the Department of Pediatrics at the University of Arkansas for Medical Sciences (UAMS) College of Medicine. He will assume both posts in October.

Dr. Adams will take over from the founding director of the Nutrition Center, Thomas M. Badger, PhD, a neuroendocrinologist who is currently professor and chief of Developmental Nutrition. Dr. Badger intends to continue his research on the effects of maternal and infant nutrition on development and disease prevention.

Dr. Adams comes to Little Rock having supervised an expansive laboratory producing innovative research into insulin resistance, fructose metabolism and metabolic profiles associated with obesity and type 2 diabetes. He previously worked as a scientific investigator for Amylin Pharmaceuticals, Novartis Pharmaceuticals and Genentech.

Dr. Tom Badger helped define the vision for ACNC, which was established in 1995 as the sixth of the USDA's National Human Nutrition Centers. It is only the second of these centers devoted to children.

The ACNC is a partnership between the USDA, ACHRI, and UAMS that conducts world-class pediatric research that in turn provides the finest, cutting-edge medical care for the children of Arkansas. It is funded by one of the largest federal research awards in the University of Arkansas System and has become a global leader among nutrition research programs.

Shoe Sale Benefits Cancer Institute

The University of Arkansas for Medical Sciences (UAMS) recently got a boost in the fight against breast cancer with money generated by the 20th Annual QVC Presents "FFANY Shoes on Sale," held in October 2013.

Supporting breast cancer research and education institutions nationwide, the Fashion Footwear Association of New York (FFANY) and QVC selected the UAMS Winthrop P. Rockefeller Cancer Institute as one of the nine beneficiaries of the 2013 event. QVC and FFANY representatives presented a check in the amount of $342,143 to Cancer Institute Director Peter Emanuel, MD, and V. Suzanne Klimberg, MD, director of the UAMS Breast Cancer Program, who accepted the donation on behalf of the organization.

Since its inception, QVC Presents "FFANY Shoes on Sale" has sold more than 1.7 million pairs of shoes and generated more than $44 million to benefit leading breast cancer research and education institutions. Designated as the event's "Special Pink Benefactors" in 2013, The Nine West Group, Brown Shoe Company and Camuto Group each donated shoes worth more than $500,000. Their contributions included brands such as Nine West, Anne Klein and Easy Spirit, as well as Via Spiga, Franco Sarto, Naturalizer, Vince Camuto, Jessica Simpson, and VC Signature.

The Fashion Footwear Charitable Foundation was created to support ongoing research and education programs in the fight against breast cancer and is supported by members of the Fashion Footwear Association of New York (FFANY).

For more information go to www.FFANY.org.

Breast Center Offers 3-D Mammograms

The Breast Center at the UAMS Winthrop P. Rockefeller Cancer Institute has announced the addition of 3-D mammography technology to its full array of services. The UAMS Breast Center is the only facility in central Arkansas to offer this advanced breast cancer screening tool.

Known as breast tomosynthesis, the 3-D screening technology has been shown to detect a 41 percent increase of invasive breast cancers and a 29 percent increase of all breast cancers, according to a study published in the June 25, 2014 issue of the *Journal of the American Medical Association* (JAMA).

The UAMS Breast Center routinely uses tomosynthesis technology for all women receiving baseline — or first-time — mammograms, those who have previously been diagnosed with breast cancer and all women known to have dense breast tissue. It also is available for any woman by request.

While digital mammography is still considered one of the most advanced breast cancer screening tools available, tomosynthesis provides a view of the structures within the breast — such as milk ducts, fat, ligaments, and blood vessels — from angles not available on a traditional 2-D image.

The JAMA study, titled "Breast Cancer Screening Using Tomosynthesis in Combination with Digital Mammography," involved almost 500,000 exams at 13 academic health centers and community-based screening sites across the country.

Not only is tomosynthesis a significant advancement in detecting breast cancer, it also has been shown to reduce the number of women called back for additional, unnecessary testing by 15 percent.

"By reducing the number of women who have to return for additional testing, we not only save money but also reduce stress and anxiety," Fincher said.

In addition to screening and diagnostic mammography, UAMS Breast Center offers imaging and procedures including breast MRI, ultrasound, cyst aspiration, needle localization, core biopsy (stereotactic, ultrasound and MRI guided), and ductogram. ■

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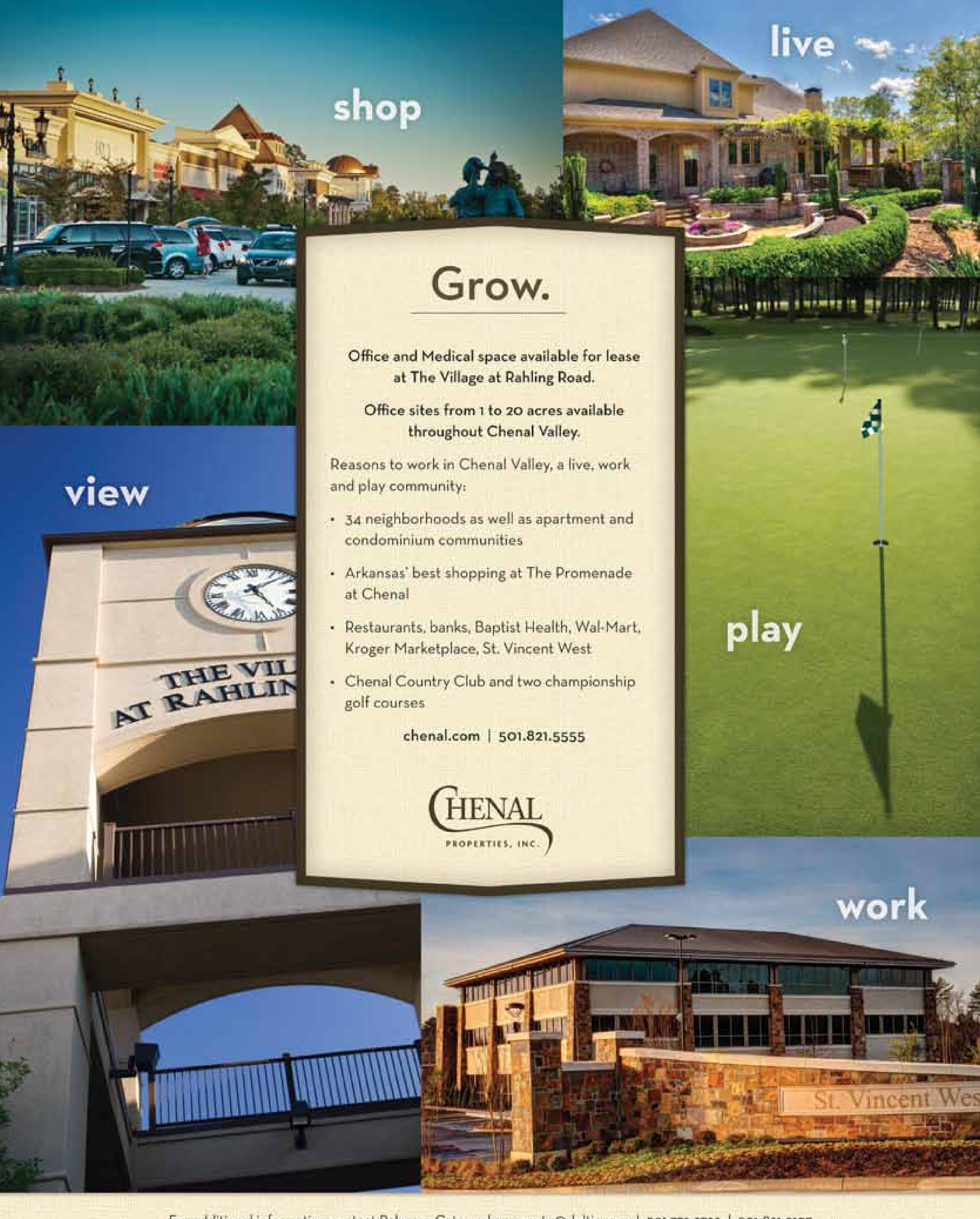

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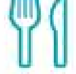
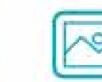

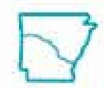

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